Canada. Royal commission on health services.
Hearings. v. 9-10. 1961.

1964

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

CHARLOTTETOWN

P. E. I.

VOLUME NUMBER:
9

DATE:
NOVEMBER 8 1961

OFFICIAL REPORTERS
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ROYAL COMMISSION ON HEALTH SERVICES

I N D E X

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Canadian Mental Health Association
P. E. I. Division

Brief 1987
Evidence 2121

COMMISSION MEMBERS:

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Miss ALICE GIRARD, R.N.

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Prof. O.J. FIRESTONE

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COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

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Prof. BERNARD STERNEN

LAFRANCE

Charlottetown, P.E.I.,
Wednesday,
November 8th, 1961.

--- On resuming at 10:00 a.m.

THE CHAIRMAN: The Canadian Mental Health Association, Prince Edward Island Division.

SUBMISSION OF THE CANADIAN MENTAL HEALTH ASSOCIATION, PRINCE EDWARD ISLAND DIVISION

APPEARANCES:

Mr. A. H. Peake

Dr. J.H. Maloney

Dr. M.N. Beck

Mr. Urban McQuaid

MR. PEAKE: Mr. Chairman and members of the Royal Commission, on behalf of the Prince Edward Island Division of the Canadian Mental Health Association I wish to extend our very warm welcome to the welcomes already delivered to you by previous organizations. Some measure of the warmth of our welcome may be indicated by the weather: we have kept our weather in eastern Canada the warmest in the country during your visit here. We have also attempted to retain some of our beautiful fall foliage beyond the usual date; they are usually pretty stark and bare at this time. We are very happy you have come to this province.

First, I would like to introduce my colleagues who are supporting me in this brief. Two of them have already spoken before the Commission, but today they are wearing different hats. First, I would like

Charlottetown, P.E.I.,
Wednesday,
November 6th, 1961.

[illegible]

[illegible] OF THE CANADIAN MENTAL HEALTH ASSOCIATION,

[illegible]

Mr. A. R. Peake

[illegible]

[illegible]

Mr. [illegible] McQuaid

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to introduce myself: I am past president of the Division, presently Chairman of its Board of Directors, and as past president I originally signed the brief submitted to you this morning. Our President Dr. J.H. Maloney, you have already met; the Chairman of our Scientific Planning Committee, Dr. Malcolm Beck, and Mr. Urban McQuaid, our Executive Director.

Perhaps it would be helpful to the Commission to give a brief history of our organization. The Division was formed in October 1959 and, like most of the health organizations, was born out of the need for public interest in a health problem, this health problem being the very vital and important problem of mental health.

The Division is organized into general membership, a Board of Directors elected by the general membership, and due to the wisdom of those who organized this mental health association in eight other provinces in addition to our own, has, as a very agile adjunct, a scientific planning committee. Our objects might be briefly summed up in this way: we have three main objects in the mental health organization. First, the organization of the public, the prevention of mental illness through positive mental health, and through research, and thirdly bringing a closer relationship between our mental hospitals and the public who are volunteer activities. Our problem when we formed two years ago was to discover an effective role we might play in the solution to the mental health problems of Prince Edward

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Island. The first thing to be decided was, what is the problem, and I would like to read and indicate to you two paragraphs from the introduction of the survey which we prepared for our provincial government this year.

> "Mental and emotional illness is without doubt the most difficult and most important health problem we have in Canada today. The magnitude of the problem can be readily understood when it is realized that there are over 70,000 patients in Canadian mental hospitals, and that, if the present trend continues, one out of every twelve children born in Canada this year will spend a part of his life in a mental hospital. Mental and emotional illness is crippling more people today than cancer, heart disease polio and all other physical diseases combined. That the problem is at least as serious in Prince Edward Island as in the rest of Canada scarcely requires proof. It is worthy of note, however, that there are at the present time almost 400 beds set up in Riverside Hospital and that the occupancy rate for those beds is at a

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consistently high level. In addition, it should be noted that 2700 patients have been treated in our mental health clinics since they were established in 1952. This, in itself, is a rather startling figure, and it must be remembered that for only two years of this period were the clinics operating with an adequate staff.

Just how many other residents of the province are suffering from mental and emotional disturbances, but who are not receiving hospital or clinic care, we have no way of determining. We can safely assume, however, that there are a great many such people, struggling on by themselves, convinced that their symptoms cannot be cured. It is tragic to contemplate just how many people there are who are terribly handicapped by mental and emotional disorders and who are carrying on, doing the best they can, unaware that modern psychiatric treatment could make an enormous difference in their health and well being."

That, gentlemen, being the problem, our

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That, gentlemen, being the problem, our

directorate asked our scientific planning committee to prepare an exhaustive survey of the mental health problem of Prince Edward Island, and that was carried on over the year 1960 on to 1961, and last March this survey was presented to our provincial government, and I would like to assure the Commission that this was a survey which was prepared by well qualified personnel of varying professional qualifications. For instance, if you look at our scientific planning committee, we have on it, amongst others, Mr. Malcom MacKenzie, the Deputy Minister of Education for the province; Mr. E.A. MacDonald, the Director of Child Welfare; Dr. Beck and Dr. Theriault, psychiatrists; Mr. Reginald MacDonald, the principal of one of our largest schools. Then, in the sub-committees, on geriatrics, Miss Doris Anderson, nutritionist; Dr. Drysdale, a prominent internist; Brigadier Reid, the Director of Welfare and Labour -- to name only a few. If there are any particular categories you would like me to go on to, I could answer that later.

Finally, to conclude my introduction to this brief, I would say this is one of nine provincial briefs which will be presented to your Commission, and our national organization will be presenting a brief designed to consolidate and supplement these provincial briefs.

If I could take our brief, it is quite short and, with your permission I will read it to you.

[illegible]

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1. The Prince Edward Island Divison of the Canadian Mental Health Association has completed in March of this year a survey entitled "Survey of Mental Health Needs on Prince Edward Island". This study delineates the extent of the problem of mental end emotional illness in its broadest sense. It also describes the facilities available in this province for the prevention and treatment of these illnesses.

2. On page 44 of this survey is presented a "Summary of the recommendations". On page 41 is presented an analysis of the additional physical plant facilities and additional staff - medical and paramedical, necessary for the implementation of these recommendations. As well, a calculation of the annual cost of this increased staff is included.

3. We respectfully call your attention to these recommendations. Particularly,we would call your attention to certain of these.

(a) The citizen of this province is requred, if at all possible, to pay for hospitalization should he find it necessary to spend time in a mental hospital. He is unable to insure against this eventuality. The same citizen, however, has ample opportunity to insure himself against illness of any type in a General Hospital. What we wish to recommend emphatically is that any program of Health Services should provide an equal opportunity for the citizen to insure himself against the cost of all types of hospitalization.

The Prince Edward Island Division of the Canadian Mental Health Association has completed in March of this year a survey entitled "Survey of Mental Health Needs in Prince Edward Island". This study delineates the extent of the problem of mental and emotional illness in this broadest sense. It also describes the facilities available in this province for the prevention and treatment of

Of page 44 of this survey is a detailed "summary of the recommendations". On page 47 is presented an analysis of the additional physical and financial and personnel staff - medical and paramedical, necessary for the implementation of these recommendations. In sum, a maximum of the annual cost of this increased staff is

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

provide an equal opportunity for the citizens to insure himself against the cost of all types of hospitalization.

Similarly, we would emphasize that our citizen should be enabled to ensure himself against the cost of personal Medical Services involved in Mental and Emotional illness. Such insurance should be available within a comprehensive plan covering all types of illness, and should protect against such costs, whether incurred on an Out-Patient basis, in a General Hospital, or in a Mental Hospital.

This, we believe, would also aid in removing much of the stigma attached to mental illness and mental hospitals.

(b) We would also respectfully call your attention to Section 3, page 12, and Section 4, page 19, of the aforementioned survey. We call your attention to these sections because they are concerned with a comprehensive Mental Health Program for our youth. This program is focused on prevention. We firmly believe that even with the projected increase in treatment facilities as outline, we can never do other than treat the already established mental illnesses.

Therefore, a realistic Mental Health Program must include facilities for the early detection and treatment of the deviant child. We recommend the inclusion of such preventative measures in any plan of Health Care in Canada.

(c) We would call your attention also to Section 10, page 40, entitled "Research".

Psychiatric illness involves far longer lasting

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should be available within a comprehensive plan covering all types of illness, and should protect against such costs, whether incurred on an out-patient basis, in a General Hospital, or in a Mental Hospital.

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morbidity than physical disease. This is necessarily associated with a decrease in productivity and thus becomes of major importance in the economic life of this country.

Despite this, only about 1/7th as many dollars are spent on research into psychiatric illness as into physical illness.

We would recommend that any plan of Health Care envisaged should encourage vigorous research into psychiatric illness and make funds available to eliminate the present disparity.

4. Attached hereto are letters from the Prince Edward Island Command of the Canadian Legion, The Prince Edward Island Teacher's Federation, the Prince Edward Island Women's Institute, the Prince Edward Island Catholic Women's League, and the Prince Edward Island Federation of Agriculture; all endorsing the principles and recommendations contained in this submission.

5. This, we submit, indicates a broad base of public support for the principles contained herein.

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C O N T E N T S

[illegible]ter to the Premier of Prince Edward Island from the [illegible]t, Prince Edward Island Division, Canadian Mental Health Association.

[illegible]ote to the Late Dr. A. J. Murchison

Members of Summerville Planning Committee, Prince Edward Island Division, Canadian Mental Health Association, together with members of sub-committees who assisted in the preparation of this Survey.

Charlottetown, P.E.I.
March 20th, 1961

Honourable Walter R. Shaw,
Premier of Prince Edward Island,
Charlottetown,
Prince Edward Island

Dear Mr. Premier:

On behalf of the Prince Edward Island Division of the Canadian Mental Health Association, I wish first of all to express our pleasure in the constructive and helpful attitude of yourself and of individual members of your Government in matters pertaining to the work of our Association. The moral and financial support provided to our Division from its earliest beginnings has been most gratifying to all of us.

As you are aware, a number of reports and surveys dealing with some aspects of mental health and mental illness have been presented to various Provincial Governments throughout the years. It is considered, however, that the study now presented is unique in that it encompasses a much greater area of concern than did previous reports; and that it was prepared by a highly-qualified group of Island residents who are deeply interested in all matters concerning the mental health of our people.

The Prince Edward Island Division of the Canadian Mental Health Association has observed with interest and gratification the increasing recognition by Government of the tremendous problem of mental illness, and hopes that this survey will assist in the planning of future improve-

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Respectfully submitted on behalf
of The Prince Edward Island
Division, Canadian Mental Health
Association,

Arthur H. Peake
Provincial President

THE LATE DR. A. J. MURCHISON

The members of the Prince Edward Island Division of the Canadian Mental Health Association were profoundly shocked and sorrowed to learn of the sudden death of Dr. A. J. Murchison.

Dr. Murchison was one of the prime movers in organizing this Division, and his friendship and wise counsel will be greatly missed in the years to come. He was a valued member of the Division's Scientific Planning Committee, and with his long experience and broad knowledge of mental health problems he contributed in great measure to the preparation of this survey.

The people of Prince Edward Island owe a great debt to this dedicated man, who laboured through dark days to bring enlightened care to our mentally ill.

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SCIENTIFIC PLANNING COMMITTEE

PRINCE EDWARD ISLAND DIVISION, CANADIAN MENTAL HEALTH ASSOCIATION

M.N. Beck, M.D., C.M. -Chairman

R.M. Ewing, M.A.

R.D. Drysdale, M.D.,C.M.,F.R.C.P.

J.C. Theriault, M.D.,C.M.

J.H. Maloney, M.D., C.M.,M.R.C.O.G.

E.A. MacDonald, M.S.W.

Malcolm MacKenzie, B.A., M.Paed.

A.H. Peake, B.A.,LL.B.

J. Reginald MacDonald

A.J. Murchison, M.D., C.M. Ex Officio (deceased)

Sub-Committees for Preparation of this Survey

Mental Health Clinics

R.M. Ewing, M.A.)
) Co-Chairmen -
J.Reginald MacDonald)

J. Berdala, M.D.

Geriatrics

R.D. Drysdale,M.D.,C.M.,F.R.C.P. (C) Chairman

Brigadier W.W. Reid, B.A.

Doris M. Anderson, M.Sc. -

J.C. Sinnott, M.D., C.M., F.R.C.P. (C)

R.G. Lea, M.D., C.M.

Mental Hospitals

J.C. Theriault, M.D., C.M. Chairman

M.A. Deacon, M.D., C.M. -

Laura O. Kitchen, R.N.

M.M. Beck, M.D., C.M. -Chairman

R.M. Ewing, M.A.

R.D. Dryadale, M.D., C.M., F.R.C.P.

J.C. Thorlault, M.D., C.M.

J.H. Maloney, M.D., C.M., M.R.C.O.G.

[illegible]

Malcolm MacKenzie, B.A., M.Ped.

A.H. Peake, B.A., LL.B.

J. Reginald Macdonald

A.J. Murchison, M.D., C.M. Ex Officio

Sub-Committees for Preparation of this Survey

[illegible]

R.M. Ewing, M.A.)
J.Reginald Macdonald) Co-Chairmen -

[illegible]

Geriatrics

R.D. Dryadale, M.D., C.M., F.R.C.P. (c)
Chairman

Brigadier W.W. Reid, B.A.

Doris M. Anderson, M.Sc. -

J.C. Stimott, M.D., C.M., F.R.C.P. (c)

F.G. Lea, M.D., C.M.

Mental Hospitals

J.C. Thorlault, M.D., C.M. Chairman

M.A. Deacon, M.D., C.M. -

Laura C. Kitchen, R.N.

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3 A. G. Laws, M.S.W.

4 David Boswell, M.Sc. (Phys. Ed.)

5 Frank Lacey

6 Mental Health in the School

7 Malcolm MacKenzie, B.A., M. Paed.,
Chairman

8 K.A. Parker, M.A.

9 Carrie Thomson

10 Elinor MacDonald

11 Mental Health of Children

12 M.N. Beck, M.D., C.M.)

13 Co-Chairmen
E.A. MacDonald, M.S.W.)

14 K.R. Parker, M.D., C.M.

15 J.H. O'Hanley, M.D., C.M.

16 Penal Policy and Institutions

17 A.H. Peake, B.A., LL.B., Chairman

18 J.F. MacMillan, B.A.

19 J.S. Cutliffe

20 Charles F. Bentley, B.A., LL. B.

21 John P. Nicholson, LL.B.

22 (and in consultation with key law officers

23 of the province, and the Federal Commissioner

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25

26

27

28

29

30

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INTRODUCTION

The Canadian Mental Health Association and its Provincial Divisions have on many previous occasions submitted briefs to Federal and Provincial Governments. It is a matter of satisfaction to the Association that such briefs have been well received and that the recommendations contained therein have been given serious and sympathetic consideration. The survey herewith submitted marks the initial experience of the Prince Edward Island Division of the Association in such an undertaking. This Division is confident, however, that the Government of Prince Edward Island will afford their survey a similar measure of interest and attention.

In the preparation of a report on mental health services, it must always be borne in mind that good mental health involves a much broader areas of concern than that provided by clinical and treatment services. When we consider the prevention of emotional breakdown, we must also concern ourselves with the home, the school, our welfare services and many other aspects of our society. All of these can and do play a part in mental ill health. In preparing this survey we have followed this broad concept.

Mental and emotional illness is without doubt the most difficult and most important health problem we have in Canada today. The magnitude of the problem can be readily understood when it is realized that there are over 70,000 patients in Canadian mental hospitals, and that, if the present trend continues, one out of every twelve children born in Canada this year will spend a part

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Just how many other residents of the Province are suffering from mental and emotional disturbances, but who are not receiving hospital or clinic care, we have no way of determining. We can safely assume, however, that there are a great many such people, struggling on by themselves, convinced that their symptoms cannot be cured. It is tragic to contemplate just how many people there are who are terribly handicapped by mental and emotional disorders and who are carrying on, doing the best they can, unaware that modern psychiatric treatment could make an enormous difference in their health and well-being.

Together with the general citizenry of the Province, the Prince Edward Island Divison of the Canadian Mental Health Association has observed with pleasure the increased recognition by Government of the tremendous problem of mental illness as evidenced by the establishment

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Together with the general citizenry of the Province, the Prince Edward Island Division of the Canadian Mental Health Association has observed with pleasure the increased recognition by Government of the tremendous problem of mental illness as evidenced by the establishment

of improved services for the prevention and treatment of mental disorders. Among the more outstanding advances are the expanding social work program, the child guidance clinics, the improved physical plant at Riverside Hospital and the projected home for retarded children.

Since its formation in October 1959, the Prince Edward Island Division of the Canadian Mental Health Association has interested itself in all developments concerned with the welfare of our mentally ill, whether instituted by government, private groups or by individuals. The Scientific Planning Committee of the Association, with the assistance of a wide representation of well-qualified persons, has for the past twelve months conducted a thorough study of the problems of mental illness as they apply to Prince Edward Island. The Association now considers itself competent to submit to the Provincial Government a survey which it feels will be of assistance in the planning of present and future improvements in the mental health field.

In submitting their survey, this Division of the Canadian Mental Health Association does not consider that all the suggestions and recommendations contained therein will be immediately implemented, or that they will be brought to fruition in exactly the form recommended. It is rather the hope of the Association that this survey will assist the Government in establishing a long-range planning program for increased services in the field of mental health.

The Canadian Mental Health Association, together with its Prince Edward Island Division, realizes that Government should not be expected to bear the full burden of the problem of mental illness, and for this

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The Canadian Mental Health Association, together with its Prince Edward Island Division, realizes that Government should not be expected to bear the full burden of the problem of mental illness, and for this

reason the Association stands ready at all times to assist the Government by complementing the professional services which it provides. Among the Association's functions and activities are the sponsoring of research programs to discover new and better wasy to cure and prevent mental illness; the conducting of a continuous program of public and professional education on the nature, treatment and prevention of mental illness, and on the principles of good mental health; and the establishment of volunteer groups to work directly with patients in and out of the hospital setting.

Although the public is becoming more aware ot the needs in the mental health field, we would point out that this interest has yet to be reflected in proportionate expenditures for those suffering from mental ill health in comparison with those suffering from physical ill health. That our expenditure per patient per day for those in general hospitals is at present roughly three times that per day for the patient in our mental hospital, bears silent but substantial testimony to this statement.

It will become very evident in the survey which follows that the preeminent need in mental health is for more well-qualififed staff. Effective preventative and curative measures in this field can be achieved only through the diligent efforts of trained staff, working in a person-to-person relationship with the individual afflicted by emotional distress. Because of this, it is apparent that our efforts and monies must be expended primarily in the training, the establishment, and retention, of a more adequate corps of capable workers.

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The retention of staff for these facilities presents a continuing problem. While realizing the importance of adequate salaries for these highly trained personnel, we would stress that this is but one of many factors involved in the retention of a competent staff. Of equal or greater importance are such matters as methods of administration, educational opportunities, clear definition of career possibilities, and the general morale of our Mental Health Services.

The matter of clarification and imporvement of administrative procedure is discussed within this survey. Also discussed are some aspects relating to the preparatory and on-service training of personnel. We would here compliment the government on the continuing program of affiliation with Dalhousie University, and on its recent improvement of bursary opportunities for Psychiatric recruits. At the same time, we would emphasize the need for continuing such programs, while also pointing out the need for expanding on-service training facilities, and for the expansion of the program enabling professioal staff to further their education by attendance at conferences and conentions. Also suggested in our survey are matters pertaining to the clarification of roles and career definition. We submit that close attention to matters such as these offers the solution to the continuing problem of staff loss.

By providing and retaining such staff we can rectify the present relative under-expenditure on treatment of our mentally ill, and at the same time respond in an appropriate manner to the tremendous challenge presented by Mental Disorder.

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SECTION 1

MENTAL HOSPITALS

In submitting this report the sub-committee on Mental Hospitals notes that surveys on mental hospitals have previously been presented to Government by various organizations, viz.:

1. The Canadian National Committee for Mental Hygiene (1931)

2. The American Psychiatric Association (Chamber's Report, 1953)

3. The Agnew REport (A study of the hospital requirements of Prince Edward Island-1958 and 1959)

It is felt that another comprehensive survey would be redundant as the problems of 1931 through to 1961 are largely the problems of today--lack of staff, poor administration, low wages, lack of funds, and other lesser ills.

It is strongly urged that the recommendations put forward by the above reports be implemented, and it is felt that this sub-committee's duty is essentially to remind the authorities in charge of our hospitals of the necessity of so doing. A summary of the recommendations not yet implemented is included as Appendix "A".

The Mental Hospital serves three essential roles:

1. Therapy and Rehabilitation

2. Educations (staff and public)

3. Confinement

The role in therapy which the hospitals play is a constantly changing one. Hospitalization must be considered as a phase of treatment only, phase which

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can often be avoided, and one which should be followed by social work services, out-patient clinic care, home and job placements. In short, hospitalization should be viewed as only a phase of the entire therapeutic program, the whole program having as its goal the re-integration of the patient back into society. This is "rehabilitation" in its truest sense.

The process of rehabilitation is facilitated when administrative arrangemtns between the Hospital and Out-Patient Services are such that the same professional staff members can care for the individual patient whether he is an "in-patient" or an "out-patient". This provides a "Continuity of Care" covering the patient's illness preceding, during and following hospitalization.

The standard treatments of electroconvulsive therapy, sub-coma and coma insulin, tranquilizers, anti-depressants, and psycho-therapy are essential for the treatment and the eventual recovery of the patient. Unfortunately, outmoded ideas that mental patients are completely irresponsible are still held within our hospitals. Because of this, the patients are often either smothered with kindness or held behind locked doors, rahter than being allowed to develop a sense of independence. This attitude reflects what society thinks about the mentally ill, and our hospital falls into the trap of catering to popular opinion. This does not appear to apply to other branches of medicine.

The thinking persists in our society that once the diagnosis of insanity is made, the patient automatically becomes a state problem. Hospital personnel are

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rarely consulted prior to admission or re-admission of patients; and social pressures often determine the length of hospitalization and time of discharge.

To treat the mentall ill more adequately, and more successfully, a better admission service is required. Patients can then be assessed and followed up as out-patients or in-patients; with the emphasis being placed on out-patient care, thus avoiding the social or economic disruption induced by hospitalization. For the same reason, Day Hospital Care and Night Hospital Care should also be considered; in these programs hospital treatment is offered to day patients who return home at night, or to night patients who continue at work through the day.

There is also a tendence for the community to unload unwanted or undesirable citizens on the mental hospitals. The Mental Hospital much too often becomes "the line of least resistance" for the admission of such persons. It is unfortunate that commitment to Mental Hospitals should serve as the answer for problems which are essentially social. A committal such as this often makes effective resolution of the social problem impossible, and our hospital becomes burdened with yet another "chronic patient."

Treatment and rehabilitation must not be limited to the acute patient, nor to out-patients only. Rehabilitation, though in a limited sense, should be attempted for the chronic patient as well. In this situation close supervision by psychiatrists is needed, but the major part of the work with the chronic population can be well handled by the auxiliary staff.

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Although the aim should be to keep patients out of hospitals, once admitted becomes the hospital's duty to do as little harm as possible. If the hospital is unable to effect a permanent cure and the patient becomes a so-called chronic case, the hospital should provide a stimulating environment for the patient and help him maintain his acquired skills, or even to learn new ones, rather than subject him to an environment which cannot but contribute to further deterioration of his personality.

In this context the "Foster Home" and "Boardin-Out" Program now in operation provides an excellent service. The placement of the chronic patient in a foster home, supervised by a social worker, provides a way of life for the patient which cannot be duplicated in hospital. This program has already proved beneficial to the individual chronic patient, and, as well, has relieved over-crowding in the female wards. We feel strongly that this program should be expanded.

The Psychiatric and auxiliary staff should be utilized in areas of work where each can operate most efficiently. General medical care should be left to general medical practitioners and to the consultant staff. The organization of a competent medical and consultant staff participating in Medical Staff Meetings at the hospital would greatly enhance the quality of medical care given to the patient.

We would emphasize too, that by reason of their close contact with the patients, the housekeeping, domestic, kitchen, and maintenance staff of the hospital can and do play an important role in the therapeutic pro-

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gram. To assure full effectiveness of this "Therapeutic Community" it becomes necessary for the Medical Director to have adequate control over the appointment and discipline of all staff.

In commenting on the role of education, it is to be noted that treatment and education overlap: That an enlightened and accepting community makes rehabilitation of the patient a much easier task. Education, therefore, must take many forms and is not at all confined to the formal lectures given to staff and students. These, however, are very important and the affiliation course open to the student nurses of the General Hospitals should be encouraged.

The sub-committee notes that mental hospitals are not included in hospitalization schemes generally. This omission seems to emphasize the feeling that such institutions are "different" in some way or other. This setting apart of our Mental Hospital continues to accentuate the gap between psychiatry in the mental hospital and psychiatry in the general hospital--the latter being paid for under our hospitalization scheme.

Geography, therefore, rather than diagnosis becomes the determining factor in payment. If these hospitals and these patients are set apart by government schemes, the public will consider the mental hospital, and the mental hospital's patients, in a less favourable light.

The historical background of Mental Hospital Psychiatry with its emphasis on incarceration, custodial care, and long-term stay of patients, has tended to separate psychiatry and psychiatric patients from the general

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In some areas patients are now being admitted to mental hospital on exactly the same basis as for admission to general hospital, committal procedure being used only when absolutely necessary and "voluntary forms" being abolished. This practice has proven very successful.

To facilitate efficient administration and general public acceptance it appears to us that all hospitals should be under the Hospital Services Commission. A dichotomy now exists whereby general hospitals are, in a sense, under this Commission while the Mental Hospital is under the Department of Health. Under the Hospital Services Commission, the Mental Hospital, by virtue of having a truly authoritative, rather than an advisory, Board of Trustees, would receive a degree of autonomy which is impossible under the present administrative set-up. This, we are confident, would work to the advantage of the mentally ill.

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The public must be encouraged to participate in hospital activity also. At the present time certain organizations are acting as volunteer groups at the Mental Hospital. This should be extended. Lay organizations and individuals should be encouraged to visit the hospital, and become familiar with the hospital's problems. In order to accomplish this, an extensive program of public relations and public education, such as that begun by the Canadian Mental Health Association, will play an essential role.

The problem of confinement to a Mental Hospital essentially implies that the patient is put away for the good of society or the protection of himself. Nevertheless, the hospital should not be made the scapegoat of society, and hence a depository for all its undesirable citizens. The number of patients actually requiring care in an institution is small and the trend is toward more open wards and a more open hospital. The number of patients requireing close confinement isn minimal.

The problem of confinement to Mental Hospital should be interpreted as the problem of the chronic patient. Committal procedure is seldom necessary or desirable for the acutely ill patient. The problem of the chronic patient deserves serious study. Four groups have been listed as the most common ones met in the chronic hospital population -

1. Schizophrenics (adjusting to hospital routine)

2. The regressed patient

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1. Schizophrenics (adjusting to hospital routine)

2. The regressed patient

3. Organic dementia, e.g., senility

4. Psychotic patients with physical illness

It would seem that the large part of group No. 1 could be adequately handled in a boarding-out program as mentioned previously. Groups 2 and 3 do not require intensive psychiatric services, but require good and humane custodial care. It is doubtful if these people have to be housed in elaborate, expensive hospitals staffed by high salaried, highly trained personnel. Group No. 4 obviously need attention, but much of their treatment can be provided by competent medical men, and need not be the specific concern of the psychiatrist.

In summary, it is considered that a reassessment of our concepts regarding the Mental Hospital is necessary; that staff reorganization is required so that highly trained personnel are not encumbered by routine chores; that the emphasis is swinging to rehabilitation of the mentally ill, and to keeping the mentally ill person rehabilitated; that the problems of treatment are closely interwoven with the acceptance of the mental hospital by the Government, and the acceptance of the mentally ill population by the community at large; that the problems of confinement of the chronic patient needs further observation and study.

RECOMMENDATIONS:

1. That the Mental Hospital be included under the Hospital Services Commission, in like manner to the General Hospitals.

2. That the Board of Trustees be expanded,

3. Organic dementia, e.g., senility

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1. That the Mental Hospital be included under the Hospital Services Commission, in like manner to the General Hospitals.

2. That the Board of Trustees be expanded,

and given autonomy and authority. This Board should include a member of the Mental Hospital Medical Staff; a member of the Prince Edward Island Division of the Canadian Medical Association, recommended by that Division, and a representative of the Prince Edward Island Division of the Canadian Mental Health Association, recommended by that Division.

3. That the Boarding-Out and Foster Home Program be continued and expanded.

4. That provision be made for adequate assessment of patients prior to committal, or admission, to mental hospital.

5. That the affiliation program be continued for nursing students in General Hospitals.

6. That Medical Consultants be appointed to all specialties based on competence only, irrespective of political or religious affiliation.

7. That lay participation in hospital activities be encouraged.

8. That the hospital become more active in its open ward policy.

9. That an adequate number of well-trained personnel be appointed to assure the efficient functioning of the hospital in its various roles.

10. That the Hospital Services be raised to the standard necessary for accreditation by the Central Hospital Inspection Board. This would be an important factory in determining the accreditation of the hospital for the training of psychiatric residents.

11. That the recommendations as referred

member of the Prince Edward Island Division of the Canadian Medical Association, recommended by that Division, and a representative of the Prince Edward Island Division of the Canadian Mental Health Association, recommended by that Division.

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11. That the recommendations as referred

to in the three briefs previously presented be reviewed and carried out where applicable. (See Appendix "A")

SECTION 2

MENTAL HEALTH CLINICS

Theoretical Orientation

The present trend in Mental Health planning is to emphasize community services, making it possible for the practice of psychiatry to be carried into the patient's natural environment and every day life situation. Admission to Mental Hospital is seen as only one possilbe phase in the natural history of recovery from mental illness.

In order to play their part in this process, Mental Health Clinics should function in two ways. First, by seeing the patient before he needs hospitalization. Contact with the patient is facilitated by good communication between the clinic and the general practitioners, and various organizations in the community. Secondly, by permitting discharge of the hospitalized patient at a much earlier stage of recovery through the provision of follow-up treatment in the Clinics. This works to the advantage of both the patient and the Hospital.

The Clinic Staff should work as a team and should have as a minimum, one psychiatrist, one psychologist, two social workers, and one secretary. The psychiatrist's particular function would be to maintain a close liaison between the Clinic and the general practitioners in the commujity. He should set aside a specific time each week for consultation with the general practitioners. He should evaluate the patient from a medical and psychiatric view point and take part in treatment. The psychologist should do psychological testing and also take part in treatment. The social workers' main func-

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tions would be to do social histories and also take part in treatment. Since the general tendency today is to have the patient pay for services according to his income level, the social workers would also be responsible for assessing the patient's economic situation.

The Mental Health Clinics should be located in accordance with the distribution of the population. The generally accepted principle is that there should be one Clinic for every 25,000 or 30,000 persons in the population.

Anticipated Needs for Mental Health Clinic Services

In attempting to predict where Mental Health Clinics should be placed in Prince Edward Island, this sub-committee divided the Island into geographical areas and ascertained what proportion of the Island's population lived in each of these areas. The areas will be called East, Charlottetown, Central, Summerside, and West. "East" is separated from "Charlottetown" by a line drawn across the Island from a point just east of French Village on the north coast, to a point just east of Vernon on the south coast.

"Charlottetown" is divided from "Central" by a line drawn across the province from a point just east of Rustico on the north coast to a point just west of DeSable on the south coast. "Central" is divided from "Summerside" by a line drawn across the province from a point just west of Stanley Bridge on the north coast to a point just west of Augustine Cove on the south coast. "Summerside" is separated from "West" by a line drawn across the province from a point just west of Port Hill on the north

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coast to a point just west of Egmont Bay on the south coast. The proportion of the total population falling into each of these districts was calculated by finding the number of schoolchildren in each of the districts during the year 1960. It was assumed, for purposes of this study, that the number of school children in each of these areas would correlate quite closesly with the total population living in each of these areas.

The percentage of the total population falling into each area was found to be as follows: East 22%; Charlottetown 31%; Central 7½%; Summerside 22½%; and West 17%.

It was during the year 1956 that the Mental Health Clinic in Charlottetown was best staffed with psychiatrists to serve adult cases referred to for consultation and treatment. During that year the Charlottetown Mental Health Clinic had the equivalent of one full time psychiatrist working with adult cases only. In that year 99 adult patients from the Charlottetown area were seen at the Charlottetown Clinic. Projecting from these figures to the total population of Prince Edward Island we are able to predict that it would require the equivalent of two full time Clinics for the entire Island to look after the number of adult cases requiring psychiatric consultation and/or treatment. (For Child Guidance Clinic needs, see the report on Mental Health Problems of Children.)

It would seem that the best arrangement of Clinic time would be to have a full time Clinic operating in Charlottetown, with Summerside having a Clinic

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operating two days a week, O'Leary or some other place in the western part of the Island having a Clinic one day of the week, and the eastern area having a Clinic two days a week, possibly one day in Montague and one day in St. Peter's or Souris. It might seem that the total case load would be a little too much for two Clinics to handle. However, it should be noted that with such personnel now available it would be possible to make much greater use of psychologists and social workers in these Clinics than was the case in 1956.

RECOMMENDATIONS:

1. That a sufficient number of professional workers be employed to staff two full-time Mental Health Clinics.

2 That mental health facilities for adults be re-established in presently existing Mental Health Clinics.

3. That part-time Mental Health Clinics be established in the eastern and western parts of Prince Edward Island.

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SECTION 3

MENTAL HEALTH PROBLEMS OF CHILDREN

This Province may be justly proud of the progress that has already been made in the provision of services to guard, restore and maintain the Mental Health of our children. The Division of Child Welfare was established in 1945; the Liaison Teacher program in 1954; Mothers' Allowances in 1949; the Child Guidance Program in 1955 and Speech Therapy Services in 1960. In additon to these services of Government, private agencies have done much in these fields, the Family Service Bureaus and the Protestant and St. Vincent's Orphanages deserving special mention, as does the now disbanded Children's Aid Society, the pioneer in this field.

In the provision of such services to children we are able to carry the advances in the understanding of human behavior into a preventive role. By these we attempt to prevent emotional problems from arising in the first place by adequate child welfare services; provide treatment for the child who is already emotionally disturbed, and in so doing hope to prevent this child from becoming a disturbed adult who passes his disturbance on to his own family and succeeding generations.

Much experience has already been gained in the field of Children's Mental Health from the operation of the services mentioned above. On the basis of this experience, it is possible to provide a reasonably accurate assessment of the demand for such services, and a reliable projection of the expansion which will be necessary to provide a comprehensive Mental Health program

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for our Island youth.

For purposes of lucidity we feel it best to discuss these problems under the following headings, while pointing out that our categories are but parts of a comprehensive unit, in which all personnel and services involved should work in a co-operative and integrated effort toward a common goal.

1. Child Welfare

The Division of Child Welfare now has in continuing care some two hundered and seventy-five (275) children. In addition to this, it must investigate all referrals of neglected children and endeavour, through a prolonged family counselling service or removal of children by court action, to rehabilitate the home or protect the children from further neglect. Services to unmarried mothers, a large adoptive program, investigation and follow-up of juvenile delinquent cases are also the responsibility of this Division. Along with this agency the private Child Welfare Agencies have some 35-40 children in continuing care, and provide invaluable assistance in the field of adoption.

The role of the orphanages is at present undergoing a state of flux, which is to be commended and encouraged. The numbers of children in care therein is being cut down, foster homes are being used more extensively, and institutional care of infants discouraged. It remains to be seen what particular pattern will emerge in the function of these agencies.

At present the Division of Child Welfare is seriously understaffed and unable to even come close

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to fulfilling its mandate. It is to be pointed out that without sufficient staff many deserving cases are hardly seen, and oftent with those who are seen the limited work done is in itself productive of more demands on the staff's time; leaving our children caught in the middle and our staff harried and frustrated.

The provision of "Mothers' Allowances" for mothers with dependent children provides an excellent program for preventative mental health services. We feel that this worthwhile objective can be attained only by this program being supervised by trained staff.

Recommendations:

1. That immediate steps be taken to train social workers for service in this Division. Recruits are available, bursaries should be provided.

2. A minimal staff in this Division would be seven (7) Social Workers to meet only the present demand.

3. That "Mothers' Allowances" be incorporated into the Division of Child Welfare as is done in Nova Scotia.

If the increased Mental Health of our children provided by such services is not a sufficient stimulus for the strengthening of this program--then let it be noted that the expense of such expansion will be, in long range planning, largely covered by increased efficiency in the handling of adoptions, and better supervision of our present program attendant upon increased staff.

Juvenile Delinquency

This complex problem, caused by a combination of social and psychological factors, at present receives inadequate attention.

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ed before our courts, 13 of whom were repeaters; in 1959, there were 41 cases with 6 repeaters. Many, but not all, of these cases should be thoroughly investigated. Of these 3 per year were committed to the Director of Child Welfare for foster home placement, and 3 per year for committal to institution. The remainder were placed on probation to their parents or guardians, under the supervision of the Director of Child Welfare.

The deep concern and wise judgment of our Juvenile Court authorities is here commended. Their role must of necessity continue to be the central one in handling these problems. Their function would be expedited by the assistance of personnel trained in the Behavioral Sciences.

Recommendations

1. That the services of one full-time or two half-time Social Workers be allotted specifically to this problem. (This is included in the number recommended above under Child Welfare.)

2. That a Therapeutic Program for Juvenil Delinquents be re-established in the Child Guidance Clinic; to utilize the specialized training of psychiatrists and psychologists in dealing with this problem.

3. A "Therapeutic Residence" would markedly improve our treatment of these children. (See below under "Therapeutic Residence".)

3. Child Guidance Clinics

Since the establishment of the Child Guidance Clinic in June, 1955, 552 children have been examined and/or treated there: an average of 94 new cases per year. During this period only the Charlottetown area has received adequate Child Guidance Services.

Projecting from this demonstrated demand,

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Recommendations

1. That Child Guidance Clinics be established in the Montague, Souris and O'Leary areas.

2. To supply this service will require the addition of two full-time Social Workers to the present Clinic Staff and the additional half-time service of a psychologist.

4. Speech Therapy

As this service has been in operation for only six months, our experience in this field is limited. Suffice it to say that the demand for such help has been extremely heavy. Our survey conducted in the schools (see below) has revealed an estimated 470 children with speech problems.

We would point out that there is also a considerable demand for Speech Therapy among adults.

Recommendations

1. That another Speech Therapist be started in training immediately.

2. That an eventual staff of 3 or 4 such therapists be envisioned.

5. Therapeutic Residence

Our experience is now demonstrating the need for a specialized in-patient unit for the treatment of children who have very severe emotional disturbance.

In the past 3 years an average of 4 children

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per year, 16 years and under, have been admitted to Riverside Hospital. This is a very poor environment in which to place a child.

It is estimated that 3 or 4 per year of the children under the care of the Division of Child Welfare require treatment which can be properly provided only by such an institution. Also that an estimated 2 per cent of the children seen at the Child Guidance Clinic require such care.

Of the seven children committed to Refor Institutions in our neighbouring provinces as "Juvenile Delinquents" over the past two years, it is felt that 5 of these would have been better treated in a unit such as this.

Recommendation

1. That consideration be given to the establishment of a Therapeutic In-Patient Unit for severely distrubed children with an estimated capacity of 15 beds.

2. That before this is established, requirements for staffing, building, and managing such a unit be thoroughly investigated.

3. That in view of the changing role of our orphanages mentioned above, the possibility of co-operating with these agencies in such a venture be actively considered.

6. Integration of Services

We now have a great many organizations concerned with the Health, Education, and Mental and Social Well-Being of our Children. On the governmental level; the Department of Health, with its Public Health Nurses, Dental Services, Immunization Program, Maternal and Child Health Division, along with the Mental Health Programs mentioned above; the Department of Education with its

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Of the seven children committed to Boys' Institutions in our neighbouring provinces as "Juvenile Delinquents" over the past two years, it is felt that 3 of these would have been better treated in a unit such as this.

Recommendation

1. That consideration be given to the establishment of a Treatment Unit for emotionally disturbed children with an estimated capacity of [illegible]

2. That before this is established, requirements for staffing, building, and managing such a unit be thoroughly investigated.

3. That in view of the overlapping role of our orphanage area mentioned above, the possibility of co-operating with these agencies in such a venture be actively considered.

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various divisions of Curriculum, School for the Deaf, Physical Fitness, Correspondence Courses, Vocational Training; The Department of Welfare with its Divisions of Child Welfare and Mothers' Allowances; the Dominion Department of Health and Welfare with its Family Allowance Division. On the Private Agency level, our Orphanages, our Family Service Bureaus; our specialized organizations for the Blind, the Cerebral Palsied, the Retarded, the Diabetic, etc.; our extensive program for crippled children now carried on by the Rehabilitation Council, our Red Cross, our Paediatricians, and others.

The unfortunate truth of our present situation is that these groups are working in relative isolation with an inadequate understanding of each other's particular functions, problems, or methods. This results in loss of efficiency and, at times, in appropriate handling of cases.

Recommendations

1. That, in an approach to the solution of this problem, "Bi-Weekly Discussions on Child Services and Child Problems" be set up.

These would be informal in nature and would give the various personnel working with children an opportunity to know each other, to exchange information and thus enrich the program of all.

Hopefully, as a result of such discussions, solid principles for further co-operation between our various services, and professional integration of programs could be worked out.

The Canadian Mental Health Association is seen as a logical body to initiate action on this recom-

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mendation. The co-operation of the various departments of government concerned is requested in granting time for representatives of their staff to attend such meetings.

SECTION 4

MENTAL HEALTH IN THE SCHOOL

Our schools offer an unequalled opportunity for the improvement of the Mental Health of our people. In this setting there is offered at the same time, the unique possibility of spotting emotional disorders in their very early stages, and of providing an environment conducive to healthy personality development.

On the other hand, with our children spending 5 hours a day for 200 days a year in the school setting, they become exposed to a situation which, if improperly conceived, can exert a truly negative effect on the mental health of our population. It becomes imperative, therefore, that close attention be paid to Mental Health in the school, and that adequate staff be provided to ensure the reasonable handling of all individual problem cases, and to give guidance to our teachers in Mental Health principles. Our Liaison Teachers have shown themselves to be capable of providing this service.

In an attempt to assess actual needs for such services in the schools, the "Sub-Committee on Mental Health in the School" has utilized two surveys:

1. A province-wide testing on the reading ability of all children in Grade VI--"The Prince Edward Island Grade Standards Project" conducted through the Department of Education by the Superintendents of Schools.

2. A questionnaire sent by this committee to all schools and Public Health Nurses in the province.

From the "Standards Project" it was found that 910 (38.3%) of the 2, 370 pupils in Grade VI were

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reading at a level at least two years behind their grade placement. It is realized that many of the difficulties inherent in this problem can be remedied by more adequate attention to sound educational principles. It is to be noted, however, that the causes of retardation in reading are multiple and include emotional problems, physical defect in hearing or vision, mental retardation, Specific Reading Disability, as well as unsound educational practices. All of these children deserve the benefit of an accurate assessment of their individual problems. This assessment can be provided by the Liaison Teacher, trained in Mental Health Principles and in Psychological Testing. Furthermore, many of these children deserve Remedial Reading Therapy which often requires the supervision of Liaison Teachers.

The following statistics were derived from the sub-committee's questionnaire sent to all classroom teachings in the province:

Speech Problems	470 cases
Emotional Problems	266 cases
Physical Disability	108 cases
Mental Retardation	688 cases
Total	1,532 cases

It is emphasized that while this is by no means a valid statistical survey, it does give some indication of the number of children whom the teachers see as presenting problems within the scope of this study.

This sub-committee would also draw attention to the present inadequate training in Mental Health Principles, Individual Differences, and Personality Develop-

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ment now given to students in our Teacher Training Course.

We agree with the recommendations made in the 1959 report on Mental Retardation regarding the need for Individual Advancement Classes and Day Training Classes for retarded children. We would also note that the opportunities afforded the gifted child in our schools are at present inadequate. The gifted child is not only frustrated by his present school experience, but what is worse, his unique talents are not being fully developed. We would indeed welcome favourable consideration of a policy designed to improve this situation.

We also recognize that children in a rural society such as ours are seriously handicapped in choosing their vocation. These children later find themselves poorly informed and ill-equipped to compete in our present technological society. This matter becomes crucial when our children move to the more industrialized areas to seek employment. It is evident that a properly planned Guidance Program is a necessary part of our school service.

Recommendations:

1. That a staff of at least 5 Liaison Teachers be procured.

2. That our Teacher Training Program be enriched by more instruction in Child Psychology; and that the staff of our psychiatric facilities be utilized to this end.

3. That Individual Advancement Classes and Day Training Classes be established for our retarded children.

4. That Special Classes be established for our gifted children.

5. That a program of Vocational Guidance Counselling be initiated with the employment of at least 2 trained persons.

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Classes be established for our retarded children.

That Special Classes be established for our gifted.

That a program of Vocational Guidance Counselling be initiated with the employment of at least 2 trained persons.

SECTION 5

MENTAL RETARDATION

A comprehensive report on this major problem was presented to the Minister of Health by Dr. M. N. Beck in July of 1959. (See Appendix "B")

The proposed establishment of the first unit of a cottage type Hospital-Home for these children is commended. Also noteworthy is the increasing number of Day Training Classes on the Island, and the increasing interest of our School Boards in the establishment of Individual Advancement Classes for our less severely retarded children.

The problem created by the conversion of the Provincial Infirmary from its previous role, to that of a Home for the Aged, is not covered in the above mentioned report. At present we have no institutional facilities for the care of the adult retarded.

The work of our sister organization, the Prince Edward Island Association for Retarded Children is to be admired, and is entusiastically suppored by the Prince Edward Island Division of the Canadian Mental Health Association.

Recommendations:

1. That the general program suggested in the 1959 report be implemented as soon as possible, particular emphasis being placed on "Home Strengthening" (Social Work) and Educational Services.

2. It is recommended that the serious work of our services for the adult retarded be met by the erection of a small institution (approximately 40 beds) and by more extensive use of foster home services.

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It is recommended that the serious work of our services for the adult retarded be met by the creation of a small institution (approximately 60 beds) and by more extensive use of foster home services.

SECTION 6

PRIVATE PSYCHIATRY

The Prince Edward Island Division of the Canadian Mental Health Association is pleased to observe the improvement in our Psychiatric Practice in Charlottetown. The value of such a service has already proven its worth to our citizens.

In common with the Prince Edward Island Division of the Canadian Medical Association, we would point out that the Services provided by government should be so operated as to assure the continuance of this type of practice.

With private services now available, the provision of universally free services at our government-sponsored Mental Health Clinic should be reassessed. Several alternatives are possible here:

1. That the Provision of Clinic services might be limited to those who are "mentally indigent".
2. That some form of subsidized practice of Psychiatry could be set up within our clinics.
3. That our clinics could be operated on a sliding scale of fee payment varying with income, number of dependents, etc., as is the present practice in the Mental Health Clinics of Nova Scotia.

Whatever alternative is chosen, the financial burden on our Provincial Treasury would be decreased. It should also be noted that many prepaid medical insurance plans now cover psychiatric treatment in whole or in part;

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Whatever alternative is chosen, the financial burden on our Provincial Treasury would be decreased. It should also be noted that many prepaid medical insurance plans now cover psychiatric treatment in whole or in part;

and under our present system of free service we are unable to take advantage of this source of income.

With the establishment of private practice in psychiatry, we should re-examine our present system of In-Hospital Psychiatry. There seems to be no valid reason why the privileges now given to other branches of medicine, for private practice in general hospitals, should not apply to private psychiatry in our general or mental hospitals.

Again two alternatives are suggested by this Division for further study:

1. The provision of Psychiatric Wards in our general hospitals.

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SECTION 7

ALCOHOLISM

The making and use of alcohol goes back to the dim past of man's prehistory. Since that time alcohol has been a part of the culture of both primitive and civilized peoples. It has been used as a staple of diet, as a gesture of hospitality, to enliven social occasions, to relieve minor aches and pains, to induce relaxation, and in both civil and religious ceremonies. But despite its useful properties, it has ever been a source of personal and social problems.

The the problem of alcoholism exists in this province requires no proof. As to its extent, one may safely say that it is at least as great as in the rest of Canada. There are, therefore, approximately 2,000 alcoholics in this province. Furthermore, it must be remembered that, for every alcoholic, there are at least four other people suffering because of him.

Each year there are approximately 1,750 persons convicted by our courts for offences associated with the use of alcohol. There are approximately 780 jail sentences given. The cost to this provinces in dollars and human misery is staggering.

Any program dealing with this problem should start with prevention. This will consist primarily of an educational program, the aim of which should be to teach moderation rather than total abstinence. This does not mean that any program of total abstinence, such as that carried out by the churches, would not be considered beneficial. Neither does it mean that the established alcoholic can ever

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with less than total abstinence.

This Educational Program has already been initiated under the direction of Mr. David Boswell, Director of Physical Education and Alcohol Studies. It will consist of: (a) Education of the youth in the schools (from Grade VII onwards); (b) Education of the adult through any or all of the groupings in which he can be reached: Women's Institutes, Home & School, Catholic Women's League, etc. Speakers and films will be used.

The aim of this program is to explain the dangers inherent in the use of alcohol, how to recognize the danger signs and symptoms of the pre-alcoholic stage, and to point out the services available to help the problem drinker and alcoholic, e.g. the Family Service Bureaus, medical services, Alcoholics Anonymous. The education of the employer concerning his role in the handling of the alcoholic employee should also be a part of this program.

It has been noted by the Social Welfare groups that alcoholism is more common here in winter, and the increase is doubtless due to the boredom and frustration of idleness. Some improvement might be expected when a successful Winter Works Program is operating.

Treatment:

It is considered that the treatment of the acute phase of alcoholism should take place in Riverside Hospital, since only there are adequate facilities available for handling such a patient. The patient may be admitted voluntarily or by certification.

The initial step in the process of rehabilitation must be a decision as to the further disposition of

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The initial step in the process of rehabilitation must be a decision as to the further disposition of

the patient. Such a decision can be properly made only after a thorough study of the individual himself, his social and economic situation, and his past history has been completed. For sme, immediate discharge home to the care of relatives or friends, with follow-up on an out-patient basis would be the better plan. The majority would likely require further stay in Rehabilitation Centre. In some cases it is recognized that rehabilitation is presently impossible. Such persons may requre custodial care, or where their alcoholic career brings them into conflict with the law, sentence to prison or prison farm would be indicated.

There are many opinions and ideas as to the detailed make-up and workings of a Rehabilitation Centre. Its final form could only be determined by a study of other centres now functioning in other parts of Canada and the United States, and their adaptation to the Island culture. This would be best done by those who would later be in charge of the program. It might be situated at Riverside Hospital where many of the needed facilities are already available. Again, it might be thought that a large farm house near Charlottetown would be preferable.

It should be staffed by Psychiatrists, Social Workers, Clergyment and Alcoholics Anonymouse Representatives. There would be cheerful accommodations, library, facilities for occupational therapy, gardening, etc. Individual and group therapy would be carried out, as well as treatment of the spouse and the home situation. The regular Alcoholics Anonymous meetings were periodically. Vocational training at the Vocational School could be given to any likely to benefit. Eventually, the patient would be

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discharged, under the surveillance of his Family Agency, Clergymen, the local Alcoholics Anonymous group, or the alcoholic specialist in the Mental Health Clinic.

Finally, a close liaison with the courts and, possibly, new legislation would be necessary inasmuch as the efficient working of such a program would seem to necessitate power of committal. (See Mental Hospital Acts, Revised Statutes of Ontario, 1950, Chap. 229.)

Recommendations:

1. That an adequate program be established for the treatment and rehabilitation of alcoholics.

2. That such a program be started only when the services of a half-time psychiatrist, a full-time psychologist, and two full-time social workers can be specifically allocated to this program.

3. That before the institution of this program the above-named staff be given adequate opportunity to thoroughly study similar programs in other centres.

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SECTION 8

GERIATRICS

The field of Geriatrics encompasses medical, surgical, psychiatric, social and economic problems in the older age group. In this report attention will be concentrated on institutional accommodations available for older citizens in the province, and brief mention will also be made of the need for community facilities.

On the basis of medical and economic considerations, there are several categories in which older citizens can be grouped:

(a) those who are able to maintain their own homes;

(b) those who are able to be cared for by relatives;

(c) those who are not mentally or physically incapacitated, but require domiciliary care, chiefly for economic reasons;

(d) those who are senile and cannot be cared for outside of a mental hospital;

(e) those who are chronically ill and require care in a chronic care unit in a general hospital;

(f) those who are acutely ill and require temporary care in a bed in a general hospital.

Groups (c), (d), and (e) are the immediate concern of this report. From the information we have gathered, the beds available at present, or planned for in the near future, appear to be adequate in number and distribution for some time to come. The present facilities are:

I. Domiciliary Care (This term is used in preference to "Custodial Care."

(a) Beach Grove 164 beds

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I. Domiciliary Care (This term is used in preference to "Custodial Care."

(a) Beach Grove 164 beds

(b) Provincial Home for the Aged (formerly the Provincial Infirmary) 135 beds
(c) Borden 18 beds
(d) Home for the Aged (planned to replace Sacred Heart Home) 128 beds

II. Riverside Hospital (Senile Patients)

Approximately 80 (25%) patients out of a total patient population of about 320 are age 65 or over. Not all of these 80 patients are senile, but on the basis of age classification they fall into the geriatric group.

III. Chronic Hospital Units

(a) Prince Edward Island Hospital -40 beds
(b) Charlottetown Hospital -40 beds planned
(c) Prince County Hospital -40 beds

Because of the diversity in function of our geriatric institutions, there must be careful planning in the placement of patients to ensure that the proper patient is in the proper institution.

Many factors must be evaluated in the placement of these patients. Should the patient who requires minimal nursing care be placed in a welfare institution where nursing staff is limited? Should the senile person whose only problem is wandering away require placement at Riverside? Would the patient be better cared for in a "Foster Home Program" than in institution? Is private placement possible? Is it desirable that this individual be placed close to his own home? How can we avoid overloading our Chronic Care Units in the General Hospitals? These and other questions must be evaluated before placement is made.

It is anticipated that in the Chronic Care Units of our General Hospitals the situation of the older

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It is anticipated that in the Chronic Care [illegible] of our General Hospitals the situation of the older

patient will receive more thorough study than is presently the case; and that his case will be adjudicated by the Standards Sub-Committee of the hospital concerned.

One feature that should be mentioned is that good nutrition is important in old age. Adequate dietetic supervision is lacing at Riverside, the Provincial Home for the Aged, and Beach Grove. It is planned to have one dietitian employed in a supervising capacity for these institutions, but whether one dietitian can adequately carry out this job is questionable.

Finally, reference should be made to the need for community facilities and activities for the older age group. It is suggested that many older citizens have no place to go and nothing to do for their recreation and interest. In some centers in other provinces, Senior Citizens Clubs have been established with supervised recreation and entertainment in club rooms set aside specifically for older people. This sort of project may well contribute to prevention of deterioration in some older people, and certainly could add an element of pleasure to the lives of a great many others.

Recommendations:

1. That a Geriatric Patient Placement Committee be organized. This should include representatives from the three types of facility involved (domiciliary care, mental hospital, chronic hospital unit), and a social worker could be responsible for the compilation of information relevant to the particular patient to be placed.

2. That at least one qualified dietitian be engaged to supervise nutrition in our Geriatric Institutions.

3. That the formation of Senior Citizens Clubs or similar organizations be encouraged.

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SECTION 9

COURTS AND PENAL INSTITUTIONS

Mental Health services in courts and penal institutions must be directed towards the diagnosis, treatment and rehabilitation of the prisoner. Whether this is a long process or a short process, the cost in dollars will pay great dividends in dollars and human happiness by the restoration to society of functioning human beings who will contribute good towards, rather than foist evil upon, their fellow citizens. These are not idle words. In Holland, where enlightened mental health services are in operation in courts and forensic institutions, only one person in every six thousand is in prison. In Canada, the figure is approximately double this number. In addition, there are the "hidden" dividends which will accrue when the juvenile delinquent or young crimenal is cut short in his criminal career and his talents and energies directed along proper social channels.

The people who appear before our courts for offences against society may be divided into three main classes:

1. The ordinarily-responsible.
2. The diminshed-responsible.
3. The mentally insane.

Once the details of the offence have been established and the prisoner found guilty upon the facts, the problem facing the court is that of classifying the prisoner and directing how the prisoner shall be committed, and with the intent that he is made to do penance for his crime, and also to rescue him for the benefit of society.

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The ordinarily-responsible who, knowing the difference between right and wrong, takes a calculated risk in committing the offence may be properly punished and so taught not to do it again.

The mentally insane should be committed to a mental institution where his illness is treated and, hopefully, cured. If incurable, he may be retained and so removed as a danger to society.

The middle group, the diminished-responsible, raises a more difficult problem. They are neither insane nor responsible and special consideration must be given their sentence so that they are not driven further along in crime, but are treated so that they can return to society when they are able to behave normally again.

The Provincial Courts

The system of Courts in Prince Edward Island may be detailed as follows:

In King's County, the County Magistrate has jurisdiction over all offences committed by adults within the County and also acts as Magistrate for incorporated towns and villages in that County.

In Queens County, the County Magistrate has jurisdiction over all offences committed by adults in the County except those committed within the boundaries of the City of Charlottetown, where the Stipendiary Magistrate of the City of Charlottetown has jurisdiction.

In Prince County, the County Magistrate has jurisdiction over all offences committed by adults in the County except those committed within the boundaries of the towns of Summerside, Alberton and Kensington, where

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the respective Magistrates of those towns have jurisdiction.

Juvenile Courts in the three Counties are presided over by the County Court Judges of the respective Counties with the exception of the City of Charlottetown, where the Stipendiary Magistrate of the City of Charlottetown presides over the Juvenile Court of that City.

The County Courts of the three Counties are presided over by the respective County Court Judges of each Court, and the Supereme Court Assizes are held in each County at certain terms each year.

Thus we have two County Court Magistrates (the same Magistrate performing his duties in Kings and Queens Counties), one City Magistrate in Charlottetown, two Town Magistrates in Summerside and Kensington, the County Magistrate for Prince also acting as Magistrate in Alberton, or a total of five Magistrates for the Province. County Magistrates Courts are held in Georgetown and Souris for Kings County, Charlottetown for Queens County and Summerside and Alberton for Prince County. Thus it will be seen that mental health services for the Magistrate Courts would not be a difficult administtayive problem, and the same obtains for our Town, Juvenile, County and Supreme Courts.

Policing

With the exception of Georgetown and Montague in Kings County, Charlottetown and North Rustico in Queens County, Summerside, Kensington, Alberton and Tignish in Prince County, all of which have Police Forces, policing in the Province is carried out by the Royal Canadian Mounted Police.

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Penal Institutions

County Jails are located at Georgetown in Kings County, Charlottetown in Queens County, and Summerside in Prince County. Other than overnight lock-ups in Charlottetown and several towns and villages, these are the only custodial institutions where prisoners are committed in the Province. To phrase a description of the County Jails in kindest terms, they are not a credit to the Province. They are not constructed to provide for proper segregation of different classes of prisoners by ages, type of offence or any other classification. They are not equipped to provide any tupe of training, exercise or recreation. They are merely custodial institutions where the prisoners fester in drab, often filthy surroundings, where discipline is honoured more in the breach than the observance, where criminal tendencies and criminal ideas find a veritable hot-house in which to flourish. The truth of these statements is best illustrated in the fact that prisoners before sentence have requested committal to penitentiary rahter than spend a further term in our County Jails. The fate of the diminished-responsible committed to pay a penalty in an institution of this type is not hard to predict but tragic to contemplate. In fairness, it must be stated that these conditions have existed for many, many years and blame cannot be attached to any particular government. The conditions exist, however, and should not be permitted to continue.

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A practical plan to provide mental health services to our Courts is not too difficult to detail, provided that it is done in a closely integrated effort of the

Department of Health and the Department of the Attorney-General.

First it involves professional aid to our police and court officers including training of those who arrest, who control, and who conduct the trial of the accused. Professional aid by diagnosis and report should be made available to the court officers at trial. It is strongly suggested that medical and social files should be established and maintained for all prisoners whose medical or social histories may be pertinent to their offence. Such files should accompany the prisoner at all stages of his trial and punishment, and be available to all persons who may have to do with the prisoner.

The full time services of a social worker should be made availabe to the courts for investigation, report and follow-up. This social worker would have available the professional services of the staff of the Mental Health Divisbn of the Department of Health.

It is considered that all officials involved in the process of arrest, trial and custody of accused persons would profit from instruction in basic mental health principles. In the course of their routine duties, police officers frequently become responsible for the apprehension, transportation, and custody of citizens suffering from acute mental illness. It should, therefore, be mandatory for police personnel to receive training in the proper handling of such persons.

Any plan to improve and to deal with mental health services in our penal institutions should be carefully integrated with the developments taking place in our

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It is considered that all officers involved in the process of arrest, trial and custody of juvenile

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federal penal institutions. This report has been drafted in accordance with the comments of Mr. A.J. MacLeod, Commissioner of Penitentiaries, concerning the ways and means whereby the federal correctional system may reasonably be expected to develop.

In October 1958, a Federal-Provincial conference on Penal Reform was held arising out of the recommendations of the Fauteux Committee, which had conducted an intensive study into the Canadian penal system. The representatives of the respective Governments, subject to the approval of their Governments, agreed, among others, on the following points:

1. A revised penal system would place responsibility for persons sentenced under Federal laws for a period of one year or more on the Dominion. Sentences under federal laws of more than six months, but less than one year, would be eliminated.

2. With regard to convicted personsn who are mentally ill, the Dominion would give further consideration to eliminating the provision under which persons found within three months of admission to a penitentiary to be mentally ill are a provincial responsibility.

3. Consideration to be given to the special problem of drug addicts.

4. No person under 16 years of age should be sentenced to imprisonment in a penal insitution where adults are confined, except where convicted for an offence mentioned in section

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1. A revised penal system would place responsibility [illegible] for a period of one year or more on the Penitentiary Commission. Sentences under federal laws of more than six months, but less than one year, would be eliminated.

2. With regard to convicted persons who are mentally ill, the Commission would give further consideration to eliminating the provision under which persons found within three months of admission to a penitentiary to be mentally ill are a provincial responsibility.

3. Consideration to be given to the general problem of drug addicts.

4. No person under 16 years of age should be sentenced to imprisonment in a penal institution where adults are confined, except where convicted for an offence punishable in section

413 of the Criminal Code viz. murder, manslaughter, rape, etc.

5. Responsibility for custody of female prisoners should be the same as for male prisoners.

6. Correctional resources and research would be surveyed by the Dominion and the Provincial authorities.

7. After-care Agency work to be studied and increased financial assistance considered.

Studies are presently being carried on with regard to the above and it is estimated that it will take four or five years before the program will be implemented.

Recommendations:

(A) Courts

1. That the services of a full-time social worker be made available to our Courts.

2. That an adequate system of maintaining medical and social records of prisoners be established.

(B) Training of Personnel

1. That police officers and other law-enforcement personnel be given training in basic mental health principles, and especially in the proper handling of the acute psychotic.

2. That the staff of the Mental Health Services be made availabe to give such instruction.

(C) Present County Jails

1. That these be used as lock-ups for overnight custody, and for the custody of prisoners awaiting trial.

2. That facilities be provided within the buildings

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ers should be the same as for male prisoners.

6. Correctional resources and research would be
surveyed by the Dominion and the Provincial
authorities.

7. After-care Agency work to be studied and
increased financial assistance considered.
Studies are presently being carried on with
regard to the above and it is estimated that it will take
four or five years before the program will be implemented.

(A) Courts

1. That the services of a [illegible]
be made available to our Courts.

2. That an adequate system of substituting medical
and social records of prisoners be established.

(B) Training of Personnel

1. That police officers and other law-enforce-
ment personnel be given [illegible]
health principles, and especially in the proper
handling of the acute psychotic.

2. That the staff of the Mental Health Services
be made available to give such instruction.

(C) Present County Jails

1. That these be used as lock-ups for overnight
custody, and for the custody of prisoners await-
ing trial.

for segregation of female prisoners, adult male prisoners, juvenile female prisoners, and juvenile male prisoners.

3. That facilities be provided for private consultation with the prisoners by psychiatric staff, social worker and after-care authorities.

4. That some facilities for occupational and recreational activities be provided.

(D) Prison Farm

That a provincial prison farm be established to which adult male convicted persons would be sentenced who are presently sentenced to jail sentences in our county jails. The facilities provided in this farm should include:

1. Segregation of prisoners,
2. Treatment of prisoners who are mentally ill, including some alcoholics;
3. Occupational training of all prisoners,
4. Recreational activities.
5. The professional staff of the Mental Health Services should serve as consultants to the prison farm authorities. Their advice should be sought regarding segregation, management, and other matters pertaining to the rehabilitation of the prisoner.

The farm products and any articles manufactured by the prisoners should be disposed of so that they do not compete on the local market with products of our provincial economy.

The advice of Mr. B.W. Henheffer, Director of Prisons, Department of the Attorney-General, Fred-

male prisoners, juvenile female prisoners, and

3. That facilities be provided for private consultation with the prisoners by psychiatric staff, social worker and after-care authorities.

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3. Occupational training of all prisoners,

5. The professional staff of the Mental Health

prison farm authorities. Their advice about

and other matters pertaining to the rehabilitation of the prisoner.

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The advice of Mr. D.W. Hambleter, Director of Prisons, Department of the Attorney-General, Pro-

ericton, New Brunswick, should be obtained. He has attained national standing in this type of program.

(E) Female and Juvenile Prisoners

That reciprocal arrangements be made with Nova Scotia or New Brunswick, whereby adult female and juvenile offenders under sentence would be committed to the appropriate institutions in those provinces and that this province accept similar numbers of their adult male offenders for custody care.

(F) John Howard Society

That strong support and ever encouragement be given the newly formed Provincial Branch of the John Howard Society.

We submit that these recommendations provide for facile integration into the program outlined at the above-mentioned Federal-Provincial Conference.

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SECTION 10

RESEARCH

While great strides have already been made in the understanding of the nature and causation of mental illness, much remains to be discovered by further research.

It appears unrealistic to us that our Government should spend large sums in the provision of services while totally ignoring this area of great need and great promise.

As well as our benefiting from the basic scientific value of such research, the institution of a research project in our Mental Health program would improve the quality of our service by providing such checks as follow-up studies on patients who have received various forms of therapy. It has also been repeatedly shown that an active research program provides a vitalizing and stimulating effect on the entire service.

Prince Edward Island offers an ideal natural laboratory for the study of many aspects of mental disorder. The concentration, stability, and mixed ethnic origin of its population; the ease with which contacts can be followed up over a prolonged period; and the relative adequacy of our services make this Province uniquely suited for sociological, epidemiological and follow-up studies.

If our services are expanded in somewhat the manner set forth in this brief, we feel confident that the larger foundations, bother American and Canadian, will become interested in establishing research programs in this area. We would urge strong support for any such possibility on Prince Edward Island, and would suggest that the

While great strides have already been made in the understanding of the nature and causation of mental illness, much remains to be discovered by further research. It appears unrealistic to us that our Government should spend large sums in the provision of services while totally ignoring this area of great need and great

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If our services are expanded in scope, the

engagement of a full-time research worker would do much to encourage other organizations, and other levels of government to interest themselves in the research possiblities here.

SECTION 11

SUMMATION

The total implementation of the recommendations in this report and Appendices would require the following as additional to our presently instituted or concretely projected facilities:

1. Physical Plant

(a) A 40-bed unit for the adult retarded.

(b) An additional 20-bed cottage for retarded children.

(c) A 15-bed unit for emotionally disturbed children (arrangements for this might be made with other agencies.)

(d) Rented office space for travelling clinics.

(e) An adequate Recreational Centre and Auditorium at Riverside.

(f) A prison farm.

2. Staff

As stated in the preamble, adequate numbers of well-trained staff are of fundamental importance to the entire program.

Staff recommended herein is summarized as follows:

Psychiatrists	Staff Required	Presently Employed
Mental Health Clinic	2	nil
Alcoholic Program	½	nil
Child Program	1½	1
Riverside Hospital	3	2
Totals	7	3
Psychologists		
Mental Health Clinic	2	1
Alcoholic Program	1	nil
Riverside Hospital	1	1
Totals	4	2

The total implementation of the recommendations in this report and Appendices would require the following as additional to our presently instituted or concretely projected facilities:

(a) A 40-bed unit for the adult retarded.

(b) An additional 20-bed cottage for retarded children.

(c) A 15-bed unit for emotionally disturbed children (arrangements for this might be made with other agencies.)

(d) Rented office space for travelling clinics

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(f) A prison farm.

2. Staff

As stated in the preamble, adequate numbers of [illegible] importance to the [illegible]

Staff recommended herein is summarized as

	Staff Required
Mental Health Clinic	nil
Alcoholic Program	
Child Program	
Riverside Hospital	
Totals	
Psychologists	
Mental Health Clinic	
[illegible]	nil
[illegible]	

2. Staff (Continued)

Social Workers	Staff Required	Presently Employed
Child Welfare	7	2
Riverside and Mental Health Clinics	7½	2
Retarded Children	2	nil
Geriatrics	½	nil
Alcohol Program	2	nil
Courts	1	nil
Totals	20	4
Speech Therapists	4	1
Liaison Teachers	5	1
Vocational Guidance Counsellors	2	nil
Dietitian	1	nil
Chaplains	2(½time)	nil
Pharmacist	1(1/3 time)	nil
Records Librarian	1	nil
Industrial Therapists	3	nil

Additional Attendant Staff Required

Second Retarded Children's Cottage	8
Institution Retarded Adults	13
Therapeutic Residence	8
Ward for Physically Ill, Riverside	5
Total	34

Additional Registered Nurses Required

Therapeutic Residence	1
Ward for Physically Ill, Riverside	4

	Staff Required	Presently Employed
Child Welfare	7	2
Riverside and Monbal		
Retarded Children	2	nil
Geriatrics	½	nil
Alcohol Program	2	nil
Courts	1	nil
Totals	20	4
Speech Therapists	4	1
Liaison Teachers	3	1
Vocational Guidance Counsellors	2	nil
Dietician	1	nil
Chaplains	2(½time)	nil
Pharmacist	1(1/3 time)	nil
Records Librarian	1	nil
Industrial Therapists	3	nil
Second Retarded Children's Cottage	8	
Therapeutic Residence	3	
Ward for Hyperactivity III.	5	
T : I	14	

Additional Registered Nurses Required

	1
	4

Charge Nurses, Male and Female Divisions, Riverside	7
	12

Additional Staff Education Program Retarded Children

Day Training School Teachers	2
Individual Advancement Class Teachers	15
Home Teacher	1
Total	18

The increased cost for this staff over that presently employed or concretely projected for is calculated as $270,000 per year at present salary levels.

In conclusion, we would point out (1) that, (for purposes of comparison only), the cost to the people of Prince Edward Island of our Hospitalization Insurance Program is expected to increase by at least $115,000 per year, for each of the next 3 years, and (2) that the implementation of this broad program will provide for the first time reasonably adequate Mental Health Services to the people of this province.

Additional Staff Education Program Retarded

Chief Nurses

Day Training School Teachers	2
Individual Advancement Class Teachers	15
Total	18

The increased cost for this staff over that presently employed or concretely projected for is calculated as $270,000 per year at present salary levels.

In conclusion, we would point out (1) that, Prince Edward Island of our Hospitalization Insurance Program is expected to increase by at least $115,000 per year for each of the next 3 years, and (2) that the implementation of this broad program will provide for the first time reasonably adequate Mental Health Services to the people of this province.

SECTION 12

SUMMARY OF RECOMMENDATIONS CONTAINED IN THIS SURVEY

Mental Hospitals

1. That the Mental Hospital be included under the Hospital Services Commission, in like manner to the General Hospitals.
2. That the Board of Trustees be expanded,and given autonomy and authority. This Board of Trustees should include a member of the Mental Hospital Staff; a member of the Prince Edward Island Divison of the Canadian Medical Association, recommended by that Division; a representative of the Prince Edward Island Division of the Canadian Mental Health Association, recommended by that Division.
3. That the Boarding-Out and Foster Home Program be continued and expanded.
4. That provision be made for adequate assessment of patients prior to committal or admission to mental hospital.
5. That the affiliation program be continued for nursing attendants in General Hospitals.
6. That Medical Consultants be appointed to all specialties based on competence only, irrespective of political or religious affiliation.
7. That lay participation in hospital activities be encouraged.
8. That the hospital become more active in its open ward policy.
9. That an adequate number of well-trained personnel be appointed to assure the efficient functioning of

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That lay participation in hospital activities be encouraged.

That the hospital become more active in its outward policy.

That an adequate number of well-trained personnel be appointed to assure the efficient functioning of

of the hospital in its various roles.

10. That the Hospital Services be raised to the standards necessary for accreditation by the Central Hospital Inspection Board. This would be an important factor in determining the accreditation of the hospital for the training of psychiatric residents.

11. That the recommendations in the three briefs previously presented be reviewed and carried out where applicable. (See Appendix "A")

Mental Health Clinics

1. That a sufficient number of professional workers be employed to staff two full-time Mental Health Clinics.

2. That Mental Health facilities for adults be re-established in presently existing Mental Health Clinics.

3. That part-time Mental Health Clinics be established in the Eastern and Western parts of Prince Edward Island.

Mental Health Problems of Children

1. Child Welfare

(a) That immediate steps be taken to train Social Workers for service in the Division of Child Welfare. Recruits are available, bursaries should be provided.

(b) A minimal staff in the Division of Child Welfare would be 7 trained Social Workers to meet only the present demand.

(c) That "Mothers' Allowance" be incorporated into the Division of Child Welfare, as is done in Nova Scotia.

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(b) A minimal staff in the Division of Child Welfare would be 7 trained Social Workers to meet only the present demand.

(c) That "Mothers' Allowance" be incorporated into the Division of Child Welfare, as is done in Nova

2. Juvenile Delinquency

(a) That the services of one full-time or two half-time Social Workers be alloted specifically to this problem. (This is included in the number recommended above under Child Welfare.)

(b) That a Therapeutic Program for Juvenil Delinquents be re-established in the Child Guidance Clinic, to utilize the specialized training of psychiatrists and psychologists in dealing with this problem.

(c) A "Therapeutic Residence" would markedly improve our treatment of these children (See below under "Therapeutic Residence.")

3. Child Guidance Clinics

(a) That Child Guidance Clinics be established in the Montague, Souris and O'Leary areas.

(b) To supply this service will require the addition of two full-time Social Workers to the present Clinic Staff and the additional half-time services of a psychologist.

4. Speech Therapy

(a) That another Speech Therapist be started in training immediately.

(b) That an eventual staff of 3 or 4 such therapists be envisioned.

5. Therapeutic Residence

(a) That consideration be given to the establishment of a Therapeutic In-Patient Unit for severely disturbed children with an estimated capacity of 15 beds.

(b) That before this is established, requirements for staffing, building, and managing such a unit be

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(b) That an eventual staff of 3 or 4 such therapists be envisioned.

Therapeutic Residence

(a) That consideration be given to the establishment of a Therapeutic In-Patient Unit for severely disturbed children with an estimated capacity of 15 beds.

(b) That before this is established, requirements for staffing, building, and managing such a unit be

thoroughly investigated.

(c) That in view of the changing role of our orphanages, the possibility of co-operating with these agencies in such a venture be actively considered.

6. Integration of Services

(a) That, as an approach to the integration of health education and welfare services to children, "Bi-Weekly Discussinns on Child Services and Child Problmes" be set up.

Mental Health in the School

1. That a staff of at least 5 Liaison Teachers be procured.

2. That our Teacher Training Program be enriched by more instruction in Child Psychology; and that the staff of our Psychiatric facilities be utilized to this end.

3. That Individual Advancement Classes and Day Training Classes be established for our retarded children.

4. That Special Classes be established for our gifted children.

5. That a program of Vocational Guidance Counselling be initiated with the employment of at least 2 trained persons.

Mental Retardation

1. That the general program suggested in the 1959 report (See Appendix "B") be implemented as soon as possible, particular emphasis being placed on "Home Strengthening" (Social Work) and Educational Services.

[illegible]

[illegible]

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4. That Special Classes be established for our gifted children.

5. That a program of Vocational Guidance Counselling be initiated with the employment of at least 2 trained persons.

Mental Rehabilitation

1. That the general program suggested in the 1959 report (See Appendix "E") be implemented as soon as possible, particular emphasis being placed on "Home Strengthening" (Social Work) and Education al Services.

2. That the serious lack in our services for the adult retarded be met by the erection of a small institution (approximately 40 beds) and by more extensive use of foster home service.

Private Psychiatry

1. That the psychiatric services provided by government should be operated in such a manner as to assure the continuation of private psychiatry.

2. That the present practice of providing universally free services at our government-sponsored Mental Health Clinics be reassessed, and the following alternatives considered:

(a) That the provision of clinic services be limited to those who are "medically indigent".

(b) That some form of subsidized practice of Psychiatry be set up within our clinics.

(c) That our clinics be operated on a sliding scale of fee payment varying with income, number of dependents, etc., as is the present practice in the Mental Health Clinics in Nova Scotia.

3. That psychiatrists be permitted to practice private psychiatry in our general or mental hospitals in like manner to the privileges extended to practitioners of other branches of medicine in our general hospitals.

4. That with regard to recommendation 3, the following alternatives to the present situation be given further study:

(a) The provision of Psychiatric Wards in our general hospitals.

4. That the serious lack in our services for the aged recommended be met by the erection of a small institution (approximately 40 beds) and by more extensive use of foster home service.

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3. That psychiatrists be permitted to practice private psychiatry in our general or medical hospitals in like manner to the privileges extended to practitioners of other branches of medicine in our general hospitals.

4. That with regard to recommendation 5, the following alternatives to the present situation be given further study:

(a) The [illegible] Wards in our general

(b) Administrative rearrangement within Riverside Hospital to make the private practice of psychiatry possible in that setting.

Alcoholism

1. That an adequate program be established for the treatment and rehabilitation of alcoholics.

2. That such a program be started only when the services of a half-time psychiatrist, a full-time psychologist, and two full-time social workers can be specifically allocated to this program.

3. That before the institution of this program the above-named staff be given adequate opportunity to thoroughly study similar programs in other centres.

Geriatrics

1. That a Geriatric Patient Placement Committee be organized. This should include representatives from the three types of facility involved (domiciliary care, mental hospital, chronic hospital unit), and a social worker from the Foster Home Program at Riverside. The social worker could be responsible for the compilation of information relevant to the particular patient to be placed.

2. That at least one qualified dietitian be engaged to supervise nutrition in our Geriatric Institutions.

3. That the formation of Senior Citizens Clubs, or similar organizations, be encouraged.

Courts and Penal Institutions

1. Courts

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(a) That the services of a full-time social worker be made available to our courts.

(b) That an adeqyate system of maintaining medical and social records of prisoners be established.

2. Training of Personnel

(a) That police officers and other law-enforcement personnel be given training in basic mental health principles, and especially in the proper handling of the acute psychotic.

(b) That the staff of the Mental Health Services be made available to give such instruction.

3. Present County Jails

(a) That these be used as lock-ups for overnight custody, and for the custody of prisoners awaiting trial.

(b) That facilities be provided within the buildings for segregation of female prisoners, female juvenile prisoners, adult male prisoners, and juvenile male prisoners.

(c) That facilities be provided for private consultation with the prisoners by psychiatric staff, social workers and after-care authorities.

(d) That some facilities for occupational and recreational activities be provided.

4. Prison Farm

(a) That a provincial prison farm be established to which adult male convicted persons would be sentenced who are presently sentenced to jail sentences in our County Jails.

(b) That the facilities provided in the farm in-

(a) [illegible] the services of a full-time social worker [illegible]

(b) [illegible]

[illegible]

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(2) treatment of prisoners who are mentally ill, including some alcoholics

(3) occupational training for all prisoners

(4) recreational activities

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The farm products and any articles manufactured by the prisoners should be disposed of so that they do not compete on the local market with products of our provincial economy.

The advice of Mr. B.W. Henheffer, Director of Prisons, Department of the Attorney-General, Fredericton, New Brunswick, should be obtained. He has attained national standing in this type of program.

5. Female and Juvenile Prisoners

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6. John Howard Society

That strong support and every encouragement be given the newly formed Provincial Branch of the John Howard Society.

We submit that these recommendations provide for facile integration into the program outlined at the above-mentioned Federal-Provincial Conference.

Research

(a) That the need for research in the Mental Health field and the suitability of Prince Edward Island for such research be recognized.

(b) That every encouragement be given to the initiation of a research program in this area.

A P P E N D I X "A"

SUMMARY OF RECOMMENDATIONS CONTAINED IN PREVIOUS REPORTS AND SURVEYS CONCERNING MENTAL HEALTH PROBLEMS ON PRINCE EDWARD ISLAND, WHICH HAVE NOT YET BEEN IMPLEMENTD.

A P P E N D I X "A"

SUMMARY OF RECOMMENDATIONS CONTAINED IN PREVIOUS REPORTS [illegible] PROCEEDED WITH, BUT WHICH HAVE NOT YET BEEN IMPLEMENTED.

REPORT OF THE CANADIAN NATIONAL COMMITTEE FOR MENTAL HYGIENE

1931

1. That the Government, accept as a policy a mental hygiene programme for Prince Edward Island, with the object of preventing mental disease and promoting a health mental development, this programme to be developed by the Minister of Health to include mental hygiene clinics, psychiatric wards in the general hospital, mental hygiene service in the schools and training facilities for mental defectives, using Falconwood Hospital as the centre for the development.

2. That the Government establish a training school for mental defectives.

3. That the Government arrange with the Canadian National Committee for Mental Hygiene, (now the Canadian Mental Health Association), for a regular, periodic survey, to serve as a check and for guidance regarding the developing mental hygiene programme.

4. That an auxiliary committee be organized to promote the work of the Hospital, to interpret it to the public, to undertake the provision of entertainments and special outings, and to supply the patients with reading material, etc.

5. That Registered Nurses be in charge of all wards, male as well as female.

6. That attendants be used as supervisors only, working under the direction of a nurse in charge of the ward.

7. That organized instruction for attendants be provided, and that their promotion depend upon their ability to profit by their instruction.

8. That special wards be provided for physically ill patients.

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That attendants be used as supervisors only, women [illegible]

That special wards be provided for physically ill patients.

REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

(Chamber's Report) 1953

1. Laws regarding the care and treatment of mental defectives, psychopaths, and defective delinquents should be added to the present statutes.

2. Divided authority should be eliminated wherever possible. The department now controlled by the Department of Public Works (building repairs and engineering) should be placed under the supervision of the Superintendent and the necessary employees added to the hospital payroll.

3. Rules and Regulations

(a) Qualifications should be established for each position.

(b) The duties of each positon should be analyzed and clearly defined.

(c) Rules and regulations should be clearly defined and made available to the employees in printed form.

(d) Existing positions should be reclassified and new ones should be added when necessary.

(e) Salary schedules and payroll policies should be adjusted and revised frequently.

4. An employee should be given an opportunity to decide whether he will live in the hospital or elsewhere. Cottages for married physicians and officers should be provided for those who prefer to live at the hospital.

5. All non-psychotic mental defectives now cared for at the Falconwood Hospital should be transferred to a special institution for the retarded.

6. All alcoholic patients requiring special care and treatment should be cared for at the Falconwood Hospital.

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(b) The duties of each position should be analyzed and clearly defined.

(c) Rules and regulations should be clearly defined and made available to the employees in printed form.

(d) Existing positions should be reclassified and new ones should be added when necessary.

(e) Salary schedules and payroll policies should be adjusted and revised frequently.

4. An employee should be given an opportunity to decide whether he will live in the hospital or elsewhere. Quarters for married physicians and officers should be provided for at the Falconwood Hospital should be transferred to a special

If the number requiring treatment should annually continue at the present level, (1953), the methods now in use should be followed. If the number in residence at any given time increases to a point where isolation is practical, a separate ward should be provided.

7. Facilities for the care of severely disturbed children should be provided.

8. A recreation centre, including an auditorium, patients' library, a reading room, the canteen, game rooms, a music department, and storage and office space for the Recreational Therapy Department should be provided. A recreation field with a softball diamond should be included in this project. The building and the field should be located in the same vicinity.

9. The combination of a laundry and an auditorium in the same building is undesirable and long range plans should call for the separation of these two units.

10. Physical Plant

(a) A resevoir or tank to furnish a limited supply of water in an emergency would be desirable.

(b) A sewage disposal plant should be installed. The present situation is not desirable.

(c) Refrigerated storage space for garbage should be provided in the new kitchen.

(d) A small incinerator should be provided for the purpose of burning infected material.

(e) The installation of an emergency generator should be considered.

11. Consulting and Visiting Staff

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(b) These staffs should be organized, officers should be elected, and by-laws should be formulated. Regular meetings should be held monthly for the purpose of considering the work of the previous month. The members of the resident staff should attend these meetings.

(c) Minutes of the meetings should be kept and preserved in an accessible file.

(d) The work of these staffs should be encouraged and expanded.

12. Resident Staff

(a) The number of physicians should be increased to meet the standards of the American Psychiatric Association.

(b) The attendance at clinical conferences should include the social workers, the psychologists, student nurses, and other professional workers.

(c) Minutes of all clinical conferences should be kept. They should be filed in a loose-leaf binder for ready reference.

(d) Clinicopathological conferences should be instituted as soon as a pathological service has been established.

13. Staff conferences should be hald at regualr intervals. Both administrative and educational meetings hould be held. All executives should attend. Minutes should be kept.

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(d) In-service training for employees in all departments should be encouraged.

15. A research program might be established with the cooperation of the Dalhousie University Medical Faculty. Such a move should be explored.

16. The Pharmacy

(a) The part-time services of a registered pharmacist should be made available.

(b) The reference library needed in all pharmacies should be provided.

(c) A hospital formulary should be adopted.

18. Fireproof storage should be provided for all medical records.

19. There should be regular discussion seminars or conferences in which psychoterapeutic problems and techniques should be considered.

20. Occupational Therapy Department

(a) Provison should be made for classrooms on the wards. This would enable many patients who cannot be treated under present conditions to participate in the program.

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(c) A member of the medical staff who has some knowledge of the theory and practice of this specialty should be appointed advisor to the department.

(d) All physicians on the medical staff should be instructed in the theory and practice of occupational therapy.

(e) Treatment programs should be carefully planned by the physician and the head therapist and reviewed at regular intervals.

(f) This department should be conducted for therapeutic purposes only and the articles should not be made for sale. All forms of industrialization should be avoided.

21. Industrial Therapy

(a) Most hospitals manufacture and repair mattresses, women's clothing and bedding. The repair of shoes and men's clothing is also a standard practice. Whether or not this pattern should be followed in a small hospital is open to argument. The matter of a small industrial Therapy Department is justified, the following recommendations will apply.

(b) A building similar to the Occupational Therapy Building should be provided for the purpose.

(c) The positon of Head Industrial Therapist should be added to the personnel quota. The incumbent of this positon should be a tradesman who has had experience in production.

(d) Facilities for mattress making, upholstery, shoe

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repairing, tailoring, and other industries that may be established should be provided.

(e) The different shops should be directed by skilled workers who will be able to instruct the patient helpers.

(f) The shops should be used in the Rehabilitation program as much as possible.

22. Religion

(a) It should be possible for all patients who are able and interested to attend religious services.

(b) A closer relationship with the clergy in the community should be developed. Short courses for this group have been well received in some areas.

(c) The employment of part-time Chaplains who would co-ordinate the work and assist in the campaign to improve hospital-community relationships should be considered.

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AGNEW REPORT ON HOSPITAL REQUIREMENTS

1959

1. It is recommended that Hillsborough General Hospital be developed as its name implies, with use of the facilities for combined physical and mental illnesses, and that the 16-bed unit be opened as soon as possible for this purpose. The policy of using the building for short term care (Up to approximately three months) should be continued. A 14-bed Children's Department is urged. Close liaison with all hospitals on the Island and their medical staff should be encouraged, along with educational programs for them and for student nurses and graduates.

2. It is also recommended that favourable consideration be given to the creation of a Board of Trustees made up of leading citizens to direct not only the Hillsborough General Hospital, but also all mental institutions, such Board to be under the Department of Health or, if mental care is included later under the hospital services insurance, under the Commission.

3. Board of Governors for Mental Hospitals

The desirability of setting up a Board of Governors or Trustees for the mental institutions has been considered. Usually these institutions are operated directly by the Department of Health; under a Board they would still be operated by the Department, which would control the budget, but the Board, named by the Department, would be directly in charge of the administrative program.

Advantages could be summarized as follows:

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and municipally owned hospitals. In the case of Hillsborough General Hospital, which is a general hospital in a limited sense, it would be advantageous to have set-up comparable to other general hospitals.

2. By having a group of leading citizens make the efficient operation of the hospitals their primary and possibly sold public activit, the administrative problems could be given more attention and the staff more support than could be given by, or expected of, the officials of the Department who have so many other activities to conduct.

3. Government projects and particularly mental institutions ("snake pits", et cetera) are prone to political and public criticism. A Board could be a buffer between such criticism and the Minister and his officials. Actually a well-chosen board of prominent citizens, more or less apart from the arena of politics, could be a strong deterrent of public criticism.

4. Facilities for the care of mental patients are often inadequate, largely because Departmental employees do not feel free to insist upon the same attention being given to these activities as in the case when other matters are brought before the Cabinet or the respective Ministers by out-

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5. Should the mental hospitals come under the Hospital Services Commission as has been seriously proposed, it would add to the uniformity and integration of the program if all of the hospitals coming within the scope of the hospital insurance program should have comparable types of organization.

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DEPARTMENT OF HEALTH

DIVISION OF MENTAL HEALTH

Mental Health Clinic
Charlottetown, P.E.I.

The Hon. Dr.M.L. Bonnell
Minister of Health,
Province of P.E.I.

July 20, 1959

Re: A Suggested Program for the Care of "Mentally Retarded Children" on Prince Edward Island.

Dear Mr. Bonnell:

In May of this year the Government of Prince Edward Island sent me on tour to examine the programs on the management of the "mentally retarded" in several leading centres. I wish to thank you and your Government for exposing me to this valuable professional experience which, although strenuous, was enjoyable; I trust that the time and money involved were well spent.

The following report cannot help but be highly influenced by my personal opinions, however, I have tried to tone these down wherever possible, and on this tour made a definite point of checking my own views against those of others more experienced and more competent in this field than myself.

"Mental retardation" presents our society's concern for its less fortunate members with a very definite challenge. It also presents us, as professionals, with a problem of many facets, some of which have been met, with proven techniques, and others for which new techniques will have to be developed.

The problem outlined below is based primarily on techniques well proven in other areas; but also con-

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tains some methods not as widely established. The highly rural nature of our Province and its small population necessitate some innovations:

OUTLINING THE PROBLEM

1. Definition

Although a precise definition of "mental deficiency" or "retardation" is almost impossible, the following is a somewhat satisfactory one: "Mental retardation is a symptom usually permanent, which manifests itself in a given environment by varying degrees of social incompetency due in whole or in part, to intellectual limitation". It is not to be confused with mental illness, which may be likened to "irrationality" while mental deficiency may be likened to "inadequacy".

We now know some 70 different causes of mental retardation; but as yet, the cause is not known for the great majority of cases. As with persons of normal intelligence, each individual called "retarded" is distinctly different from every other retarded individual.

Although retardation has been "stigmatized" as an hereditary condition, modern research has forced us to the conclusion that hereditary factors are important in less than one-third of the cases. Especially in the more severely retarded groups "retardation" exhibits a notorious disrespect for persons, and is found with equal frequency in homes of the rich and poor, the successful, the intelligent and the unintelligent.

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It is customary to consider "retardation" in three categories, graded as to the severity of the intellectual deficit.

(a) "Educable" - Individuals in this category, although limited in intellectual ability to the extent that they can be diagnosed as retarded, are yet capable of achieving a grade 2 to 5 level of education. With proper education and early training they are capable of becoming useful, independent and productive citizens although necessarily engaged in the less complex types of occupation. These people in terms of I.Q. have an intelligence range of from 50 to 70, and their mental ability in adulthood will not exceed that of an average 10 year old child. In some respects, their state is more frustrating than that of those of lower intelligence as their detection is often missed, and they are subjected to expectations at home and at school, which are beyond their ability to perform.

(b) "Trainable" - These children have an intellectual deficit of such degree as to render them incapable of becoming independent, self-supporting citizens. However, they remain with the ability to perform simple tasks, and can quite definitely contribute to the function of the home unit. As with persons of normal intelligence they are subject to the usual joys, vexations, and other emotional experiences of life. In terms of I.Q. they are usually considered to have an intelligence range of between 25 to 50, and in their adulthood their mental ability will not exceed that of an average 8 year old child.

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(c) "Non-Trainable" - These individuals have an intellectual deficit of such severe degree that they usually do not develop the ability to communicate intelligently in speech, and often do not develop the ability to walk. They are thus totally dependent on others for feeding, sustenance, and elementary care.

In terms of I.Q. their intelligence is considered to be below the range of 25-30, and as adults their mental age will not exceed that of an average 3 to 4 year old child.

II. Statistical

The generally quoted figure of 3% of the population falling into the retarded category is undoubtedly a conservative one, and I suspect especially conservative for Prince Edward Island. Using this as our base then, on Prince Edward Island we Have:

3,000 - retarded persons

1,150 - retarded children 16 and under

77 - retarded babies born on P.E.I. in 1958

Of these 1,150 children:

- 875 (75%) are "Educable"

These figures are substantiated in Summerside where as a result of a comprehensive survey we now know 20 children in the educable category among the 600 pupils in the elementary schools.

- 230 (20%) are "Trainable"

We now know about 100 of these through contact with the clinic and/or the Association of Retarded Children.

- 55 (5%) are non-educable and "Non-Trainable"

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III. Historical

Society has long ignored this problem to its own detriment. The earliest institutions in North America for the care of the retarded were founded in New York State and the Province of Ontario in the 1840's. Progress in this type of care has been erratic. Special educational opportunities for these individuals have also been irregularly provided, and in only a few areas go back over 40 years.

Prince Edward Island has good reason to be ashamed of its own performance in regard to its care of this large portion of its population, as we have taken essentially no steps to counteract the mal-effects of this condition. We have not yet organized any special teaching facilities for the "retarded", nor have we provided anything in the way of adequate institutional care for them; although some are cared for in the Provincial Infirmary.

This whole problem has recently been thrust into public attention by the meritorious, the importunate, work of the "Associations for Retarded Children". These groups, as you know, have been active on Prince Edward Isand as elsewhere. Usually they have been started by the parents of retarded children, but they are now receiving widespread support from other public spirited citizens. As a result of the efforts of the A.R.C.'s the last decade has seen widespread activity in this field - hundreds of classes for retarded children have been started; legislation regarding mental deficiency has been revised in all but 6 of the 48 states since 1950; widespread services for the "retarded" have been set up and society has awakened to its long negligence regarding this problem.

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As important as these are, perhaps the most valuable contribution of these groups has been the change which they have brought about in public attitudes toward mental retardation. If their good work continues (and almost certainly it will) it is to be hoped that this stigma will ultimately be resolved.

IV. Discrepancy Between Potential and Function

While we have to accept the fact that with our present knowledge there is little or no possibility of increasing the basic potential of the retarded individual, this is by no means true of their functional level. The striking thing about this whole problem is that consistently "retarded" people are functioning at a level grossly below their capacity, limited though this is.

Although these persons do have a great potential for happiness and for productivity on the more simple levels of effort in our society, at the present time not only is this potential unused, but in too many instances they now constitute only an emotional and material drain on the productive members of our society. To state this bluntly, where they are now parasites on society they could and should be contributors.

This is particularly true at the educable level; but also applies to the trainable level, where, although they will of necessity always be dependent, with proper early training this dependent position can be altered from that of a draining dependency to a useful dependency; they can, and should, become assets to the home in their dependent role.

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V. Stress on Families

(a) Physical - In regard to the non-trainable group, or in those rare cases where there are two or more retarded persons in a single household, the family is presented with a major problem of straight physical effort. The "Non-trainable retardates" can often be cared for rather satisfactorily at home for the first 8 to 10 years, but after this their increasing size makes home care almost impossible.

(b) Emotional - The emotional strain placed on these homes by the presence of a retarded child is a quite complex problem. Those of us who are fortunate enough to have children of normal intellignece, should realize that, because of their very normality we have within us an unconscious measuring rod which fits our particular child. This is not at all the case with the parents of a "retarded"child, and requires in those parents the kind of adjustment that most of us cannot make without help. Here, wise counselling is often necessary to prevent disturbing emotional patterns being set up in the household.

These parents are still people, and unfortunately, are sensitive to the usual stigma which society places on those who are "retarded". Possibly because of this, or for other reasons, they frequently develop a sense of guilt as parents of a "retarded" child. Many parents are able to deal rather nicely with such stresses; however, some will require individual help with their emotional problems.

(c) Social Stress - These parents must re-align their life to an extreme degree. They are often unable to get someone to care for their children, and therefore are continually bound to the home. Should they wish to go out for an

evening they are unable to use the services of baby sitters. Vacations away from home are often impossible for them. In some instances, they are unable to invite others into their home, and in many more instances are reluctant to do so because of the presence of their "retarded" child. Social dislocation such as this demands major readjustments.

(d) Stress on Siblings - "Retarded" children in the home often places a great deal of stress on their brothers and sisters of normal intelligence. The retarded child requires a disproportionate amount of the parent's time, and the normal sibling may react to this with a sense of rejection. In some cases the normal child is often unduly sensitive to the presence of the "retarded" sibling and on this account excludes his social activities from his home.

VI. The Retarded Child from the Broken Home

There are some "retarded" children in homes which are broken, or in homes too inadequate to deal with the normal problems of family life. Such conditions pose an unsurmountable problem to the retarded child, and present society at large with a situation demanding alleviation.

VII. Social Mal-Adjustment

Largely as a result of our maladroit handling of retarded children, disproportionately large numbers of retardates are found in such areas of social maladjustment as juvenile and adult delinquency, social assistance and child welfare cases. Some families present problems in practically all areas of life, school, court, marital and social; and these Multiple Problem Families demand a

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requires a disproportionate amount of the parents' time, and the normal sibling may react to this with a sense of rejection. In some cases the normal child is often unduly sensitive to the presence of the "retarded" sibling and on this account excludes his social activities from his home.

VI. The Retarded Child from the Broken Home

There are some "retarded" children in homes which are broken, or in homes too inadequate to deal with the normal problems of family life. Such conditions pose an insurmountable problem to the retarded child, and present society at large with a situation demanding alleviation.

Largely as a result of our malcovrit handling of retarded children, disproportionately large numbers of retardates are found in such areas of social maladjustment as juvenile and adult delinquency, social assistance and practically all areas of life, school, court, marital and social; and these Multiple Problem Families demand a

grossly disproportionate amount of our social agencies' time. It is estimated that of such families one-third are homes in which one or both parents are retarded. This is in stark contrast to the 3% figure of retarded people in the total population.

With proper handling of the "retarded" person during his childhood, situations like this should be avoided in later life. Indeed, in Denmark, where an adequate program for dealing with the problem of retardation has been in force for a longer time than in this country, juvenile delinquency has been shown to have no higher incidence amoung the "retarded" than among the normal population.

VIII. What Happens on the Parent's Death.

Practically all parents of retarded children are concerned as to what will happen their retarded child on their death. This problem is particularly acute with the cultural pattern of Prince Edward Island, in which so many members of the retarded child's family move to other provinces, and there set up homes unsuited to the care of their retarded sibling. This is a very realistic problem and one which must be met with legal provisions, which will guarantee to these parents the concern of society for their retarded child in such unfortunate circumstances.

Summary

Here then, beyond any point of question, we are faced with a tremendous problem, one of many facets, one in which many citizens are not nearly as productive or (perhaps more important) not as happy as they should be

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and further, one which places many of the productive members of our society under inordinate stress. This is a problem demanding great concern. It is further a problem which can be helped to a very considerable extent by the provision of an adequate program. Though such a program might seem extensive and expensive, especially in regard to its staffing, it has been abundantly demonstrated elsewhere that where these services are provided society as a whole benefits, as well as the retarded individuals themselves and the families who are faced with the immediate problem.

BASIC PRINCIPLES FOR A COMPREHENSIVE PROGRAM

1. Concern for the Individual

Our society has been blessed abundantly by two great influences. The first is that of the Christian Religion where under the favour of a loving God, we as individuals and as a society have become spiritually free, and thus enabled to direct our concern, and effort toward the welfare of our fellow man. Secondly, (and growing out of this Christian influence) we have been favoured by the British democratic tradition, under which we have become alerted to the inalienable rights of every member of our society to equal opportunity for personal development, stability, happiness, and freedom. Under these influences, our citizens have repeatedly shown themselves responsive to areas of need when such need is clearly demonstrated.

One might adduce here our provisions for public health, universal education, child welfare laws, old age pensions, and recently hospital insurance. The large number of regarded individuals on P.E.I. again

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BASIC PRINCIPLES FOR A CONTRIBUTORY PROGRAM

1. Concern for the Individual

Our society has been blessed abundantly by two great influences. The first is that of the Christian Religion where under the favour of a loving God, we as individuals and as a society have become spiritually free, and thus enabled to direct our concern, and effort toward the welfare of our fellow man. Secondly, (and growing out of this Christian influence) we have been favoured by the British democratic tradition, under which we have become alerted to the inalienable rights of every member of our society to equal opportunity for personal development, stability, happiness, and freedom. Under these influences our citizens have repeatedly shown themselves responsive to areas of need when such need is clearly demonstrated.

One might adduce here our provisions for public health, universal education, child welfare laws, old age pensions, and recently hospital insurance. The large number of regarded individuals or P.E.I. again

presents us with a clear focus of great need, and under these two great influences we can expect our people to support a comprehensive program directed to this problem. A program which attempts to give to each individual an opportunity to develop the best of which he is capable, first and foremost for his own welfare, and secondly, to serve the common cause.

II. Paramount Importance of the Home

It has been repeatedly and convincingly demonstrated in both psychiatric and child care service that any individual whether or normal intelligence or retarded will develop a more adequate personality pattern under the influence of his own home than under the influence of even our best institutions. Although there remains the odd exception to this rule, this principle has been established beyond any reasonable shadow of a doubt.

It therefore becomes mandatory that any program for the satisfactory handling of this problem must be done with this principle being as carefully adhered to as possible.

III. Secondary Importance of Substitute Homes.

Again, especially deriving from the experience of Children's Aid Societies and other child welfare agencies, the professionals concerned have been able repeatedly to demonstrate that where possible, and where good foster homes can be found, children develop more satisfactorily therein than in most adequate institutions. Again, this principle in any well rounded program will be ignored only to the detriment of the effectiveness of that program.

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IV. Home Oriented Programming.

Realizing that the home remains the buttress of our society, and also that where a satisfactory home is not in existence that substitute homes should be provided, it becomes essential that any development in the area of care for retarded children should centre on the provision of service facilities to the home and in the community rather than in the provision of large and expensive institutions, which cannot measure up to the results obtained by home-based programs.

From the experience gained through the modern techniques of social work, psychology, and psychiatry we now know that homes in crisis can often be stabilized by the provision of adequately trained and properly oriented counselling and counsellors; and if staff is adequate, that crises can often be prevented. Thus we can be reasonably sure of the practicality of this type of program although it does demand a heavy staff.

To quote the report of the California Joint Interim Committee on Education and Rehabilitation of Handicapped Children and Adults, "Families of mentally retarded children should have competent counselling and guidance to aid them in the acceptance and fulfillment of their responsibilities to their retarded children, and other members of their family, when needed to avoid the development of unhealthy attitudes within the home." "Parents have an obligation to provide for their children, and when possible and desirable should not be deprived of the privileges of having their children with them."

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this field that not only is it much better for the welfare of the handicapped individual to concentrate efforts on such staff; but also that it is less expensive to the state. Though the latter is not easy to prove, the New Jersey commission "To Study the Problems and Needs of Mentally Deficient Persons", has gone on record that, "Mentally retarded children can be trained within their homes or community setting for one-third the cost of state residential care", and "The cost of public school classes is less than one-half the cost of such services within institutions."

V. Changing Trends in Institutional Care.

In all areas I have visited, the trend is very definitely away from the Institutional Care of the "educable child". Generally the only "educable" children admitted to Institutions now, are those who, in addition to their intellectual defect, present other problems such as emotional or social disturbances. Under the limited terms of admission practiced in other areas the problem of setting up a "Training School" type of institution in Prince Edward Island is impractical if, for no other reason, than the small number of persons to be placed in such an Institution.

In New Jersey where aggressive legislation regarding community services for retarded children was introduced in 1954, the Institutions which had previously been set up for the care of the "educable" child are experiencing a very definite decrease in this type of admission, and are now projecting plans for a radical change in their Institutional Programs within the next five years. This situation is also dramatically illustrated by the Ontario Institu-

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tions where the percentage of "educable" persons in their institutions has decreased from 45% in 1939 to 20% in 1959.

These seem to be absolute demonstrations of the fact that, given adequate community services, these children can be satisfactorily and effectively cared for in their homes.

VI. Orientation to Prevention

Although the problem of our adult "retarded" population is one of major magnitude it would seem wise to concentrate our efforts toward the provision of proper care and services for "retarded children."

Many of the problmes associated with "retardation" are entirely preventible, and given adequate opportunities during their formitive years, along with continuing supervision, the great majority of our present problems with the large "retarded" portion of our population would be avoided.

VII. Development of Maximum Potential.

It is undoubtedly the right of every one of our citizens to experience the development of his or her potential to its fullest extent. This is true regardless of the degree of potential, and with "retarded" children (who are "more like persons of normal mental ability than they are different from them")the sense of achievement from a task or an opportunity well done presents the same satisfaction and rewards as that produced by a similar experience in his more talented brother or friend.

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(a) "Educable" children deserve the right of educational activities designed to meet and develop their decreased

ability to assimilate knowledge.

(b) "Trainable" children deserve the right to the development of their potential by training in social development, habit training and simple work functions.

With these the educable child can develop to a productive independent adult, and the trainable child to a productive adult in a setting of dependency.

VIII. The Relative Unimportance of Intelligence.

Beyond a critical minimum, intelligence has in a great many of the areas of life, little significance and is often a most unreliable indicator of vocational adjustment and achievement. Of much more significance as indicators of success are our personal motivation, emotional maturity, social competence, independence, and desirable work habits. In these important spheres the great majority of our mentally retarded, given consistent and intelligent opportunities and guidance, are entirely capable of excellent development.

IX. Role of the Institution.

It will be seen in this report that Institutional Facilities play only a moderately important role in the total program for the care of the "Retarded".

Primary stress should indeed be placed on Educational and Home Strengthening Services, with the Institution dealing only with cases that cannot be adequately handled by these services and other Community resources.

However, one other key role remains for the institution - it should serve as a centre and hub for the Community oriented phase of the program, and should provide

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a location for central office space and records; a location for practical experience and On-Service Training of the community workers; and finally a location in which the personnel of the institution would be stimuatled by the personnel of the educational and home strengthening programs, who in turn would be stimulated by the personnel of the institutions.

The institution should be a centre of information, communication, and vitalization, for all workers engaged in this comprehensive program.

X. The Necessity of Continuous Community Association

Repeatedly in the history of all institutions, there has occurred a stultifying influence in the loss of community interest in the institution. This is now abundantly ftrue of our Provincial Infirmary; it remains partly true of Riverside Hospital, and in the past has had an extremely oppressive influence on the patients there.

It is imperative that the program of an institution be set up to counteract this tendency. The administrative personnel must openly recognize this possibility and take aggressive action to counteract it. The community will retain its interest provided its support is asked for and encouraged.

In the case of an institution for retarded children the presence here of active functional units of the Prince Edward Island Association for Retarded Children should do much to forestall this tendency. However, in the type of institution described below, such a tendency would be particularly strong. To meet this danger some specific measures to deal with it are suggested.

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OUTLINE OF A COMPREHENSIVE PROGRAM

1. Adequate Diagnostic Services
2. Special Educational Facilities
   (a) Individual Advancement Classes
   (b) Vocational Classes
   (c) Day training Schools
   (d) Home Teachers
3. Home Strengthening Services
4. Institutional Services
   (a) Residential Care
   (b) Day Care
5. Recreational and Social Facilities
6. Professional Training and Retention of Staff
7. Research
8. Legislation

ADMINISTRATION

The program and institution outlined herein would be most adequately handled by a commission composed of representatives of government, and citizens highly interested in this field.

Failing this, the following chart represents possible lines of administration and communication within our present system.

I. DIAGNOSTIC SERVICES

Adequate diagnostic services present the basis for any well designed program. This will require the active involvement of the Child Guidance Team at the Mental Health Clinic (psychiatrist, psychologist, and social worker), as well as the active participation of the

(b) Vocational Classes

(c) Day training Schools

(d) Home Teachers

Home Strengthening Services

Institutional Services

(a) Residential Care

(b) Day Care

Research

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pediatricians of Charlottetown, and close cooperation with the general practitioners of the province. The Liaison Teachers program, which is in the process of development, will play a key role in diagnoses and case finding.

In P.E.I. we are in a rather fortunate position in regard to our diagnostic services.

II. EDUCATIONAL SERVICES

(a) Individual Advancement Classes

In the ordinary graded clasroom the "educable" child is subjected to excruciating and exquisite frustration.

This stress on the child can be largely resolved, and his acquisition of knowledge greatly increased, by placing him in an Individual Advancement Class. These are classes set up within the existing school system; kept small enough (10 - 15 pupils) to allow each student increased individual attention from the teacher. Here the child is allowed to move ahead at his own rate, and is thus not subject to the frustration imposed on him by the usual graded course, in which he is not expected to maintain position in a grossly unfair competition with his peers of greater natural endowment.

The number of such classes needed are startling (that is, startling unless one remembers the magnitude of the problem) and can be projected as follows: In the Charlottetown area working from theoretical figures we would need 6 to 8 such classes. In the Summerside area working from already established figures we need 2 to 4 such classes. In addition, in centres such as Montague,

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Kensington and comparable towns we would need 1 to 2 such classes in each community.

To derive maximum benefit it is necessary that children be started in such classes by age 7, or at the latest, 8. This requires extensive diagnostic facilities. Screening processes of all grades 1 are almost imperative, and satisfactory services of this type can be obtained only with a greatly increased development of our Liaison Teacher program. (These presonnel, as you know, are experienced teachers who have been given a one year course in mental health principles and are now functioning in the Division of Mental Health as liaison personnel between the schools and the Mental Health Clinic. They receive supervision by the clinic staff, and On-Service Training by our Psychologist). School Psychologists in the Summerside and Charlottetown areas would contribute immeasurably to the success of such a program.

"Educable" children should remain in a special class setting up to the age of at least 16, indeed, in countries with a highly developed program such as Sweden, it is now becoming common practice to keep them in such classes until the age of 20 to 21.

It should be noted that the removal of the slow learners from the ordinary classroom is of great help in speeding the progress of the students of normal intelligence.

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being equal (which is often not the case with our present high concentration of unqualified teachers in the one room schools) the retarded educable child in the one room school can move along at his own pace without unduly disturbing the academic routing of the school, and there can take advantage of the learning opportunities presented when younger students are being instructed.

This introduces the possibility of two appropriate methods of handling the "educable retarded" child in the rural areas.

1. Improvement of the Relatively Satisfactory One Room School Setting by:

(a) Increased individuation in teaching the retarded child. This is necessary, and but gives tacit recognition to what now often happens in actual practice. An "educable" child in the one room school should, where possible, and necessary, constitute a grade by himself.

(b) Improvement in the training of teachers in the education of "retarded" children at the normal school level.

(c) Increased orientation of teachers to the needs of retarded children through counselling by Social Workers, Liaison Teachers, and Home Teachers.

(d) Home Teaching Services.

2. Transportation of Retarded Children to Specialized Classes in the larger centres.

This would best be done by the parents or by voluntary groups.

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(b) Vocational Classes - Vocational classes for the "educable retarded" are needed to smooth the transition from the Individual Advancement Classes to the work situation. They should be set up for the service of children from the ages of 14 - 16 to 21. Such a program would present rather formidable problems on Prince Edward Island, in areas other than Charlottetown. There remains the uninvestigated possibility of working out some plan with the co-operation of the Vocational School; however, this is yet very nebulous, and requires further development.

It is also possible in the Charlottetown area to utilize the domestic needs of the proposed institution for retarded children, and of our other institutions, in a program of prevocational training for the "retarded".

In other provinces, which are more highly industrialized, the establishment of "Sheltered Workshops" has become a very dominant part of the community program for the retarded; this type of program is usually based on piece work in the industrial occupations. The possibility of setting up such a program on P. E. I. based on "service occupations" remains a possibility bit I would like to see some other rural area try it first. The essential link provided by sheltered workshops in the total program for the retarded elsewhere can perhaps be substituted for on P.E.I. by the utilization of, 1. Liaison with the vocational school. 2. Vocational placement in domestic or farm employment with supervision by a trained staff.

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1. A Director of Special Education -A director of special education should be added to the staff of the Department of Education. In most areas such a person is placed on the school boards of the larger cities; however, on Prince Edward Island he would be more suitably in the Department.

2. Additional Provincial Grant - With an Individual Advancement Class containing a maximum of 15 students, the cost for such a class is approximately double that of a"normal stream" class. Also, in order to attract personnel into this difficult type of teaching, it is necessary to offer a premium of $300 to $500 over that received by teachers of the "normal stream" classes. It has been found everywhere that local school districts are unwilling to assume all this financial burden, and the program of Individual Advancement Classes has prospered only when substantial additional monies for such a purpose are granted to the school districts by the provincial or state bodies. In most areas the state or provincial governments double the allotment which they give for a class of students of normal intelligence.

3. Expanded Liaison Teacher Services.

4. Permissive or Mandatory Legislation (see below)

(c) Day Training Classes

These are classes of 5 to 8 pupils set up in the community for the "trainable" retarded. In such a class emphasis is swung away from academic achievement, and is placed on social training, habit training, training manual dexterity, and training in the fundamental rules, dangers, and amenities of life. As a rule, children attend

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3. Expanded Junior Teacher Service.

4. Permissive or Mandatory Legislation (see below)

(c) Day Training Classes

These are classes of 5 to 8 pupils set up in the community for the "trainable" retarded. In such a class emphasis is swung away from academic achievement, and is placed on social training, basic training, training

such classes for only half the day. We now have two such classes operating in Charlottetown supported by the Canadian Legion and the Provincial Government, with the Charlottetown School Board providing classroom space at West Kent School.

On Prince Edward Island the only area with sufficient population demand for a permanent Day Training School is Charlottetown, and district and our present classes satisfactorily meet this need in this area. The Charlottetown area Day Training class should be placed in the proposed institution to counteract isolation of the institution from the community.

In other areas one would visualize a somewhat mobile class, possibly involving three districts with the teacher rotating from one district to the next. Such possible combinations would be the Summerside, O'Leary, and Alberton areas; and the Montague, Murray River -Murray Harbour, and Georgetown areas.

Such Day Training Schools would necessarily derive their major support from the Provincial Treasury. In other areas, where there are larger concentrations of population, this level class has progressively been included in the school system and, in many states, "mandatory legislation" has been passed obliging local school Boards to set up such classes where the demand exists. However, this system could not be used on Prince Edward Island where we have only one area with sufficient demand in itself; and it seems apparent that where three communities are involved the only method of financing such a program would be from central sources.

Lottetown School Board providing classroom space at West Kent School.

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Such a program should continue to receive partial support from the community. This would apply especially to the provision for transportation of the children, and/or teacher. If present practice can be used as a guide, this would be forthcoming from Associations for Retarded Children and other service organizations.

(d) Home Teachers

In England, in New Zealand and in many of the states of the U.S.A., mobile teaching services have been provided for "retarded" children or rural areas. In Sweden they have taken it one step further and established mobile classrooms in Volkswagen buses.

Such teachers would serve real needs in: 1. Academic Instruction of retarded children. 2. The orientation of the teacher of the local one room school. 3. Support and counsellling for the home. These services would be improved by the use of correspondence courses, which have been well worked out in other centres.

In the visualization of a comprehensive program for the retarded, we should start on an experimental basis, with one such teacher who would serve a limited, exclusively rural area; and expand this type of service as success indicates, and available staff permits.

III. HOME STRENGTHENING SERVICES

Repeatedly, in talking with personnel active in mental retardation, and in reading the literature concerning this problem one meets two constant refrains. 1. We need more counselling and orientation for families. 2. We need more supervision, and continuing supervision, of the retarded child and adult in the community.

Such a program should continue to receive financial support from the community. This would apply especially to the provision for transportation of the children, and/or teacher. If present practice can be used as a guide, this would be forthcoming from Associations for Retarded Children and other service organizations.

(d) [illegible]

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tive in mental retardation, and in reading the literature concerning this problem one meets two constant refrains.

1. We need more counselling and orientation for families.

Such services can be provided only by the provision of highly trained Social Work personnel. These people would have to be mobile as a great deal of their effectiveness would be connected with service to retarded individuals in rural areas.

They would perform the following functions:

(a) Orientation of the family to the problem of mental retardation.

(b) Assistance in home training.

(c) Assistance in home teaching.

(d) Assistance to parents in planning the most appropriate program for the child, and continuing counselling and supervision to see that this program is carried out.

(e) Continuing supervision in the community of the retarded individual beyond his discharge from special education classes and/or from the institution.

(f) Establishment of group counselling and/or group therapy sessions for parents of retarded children.

(g) Job placement of retarded individuals.

(h) Counselling of employers of retarded individuals.

(i) Foster home securement and placement.

(j) Foster home counselling.

(k) The use of foster homes as "half-way houses" between the institution and the community as transitional centres to independent community placement.

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(i) Foster home assessment and placement.

(j) Foster home counselling.

(k) The use of foster homes as 'half-way houses' between the institution and the community as [illegible] placement.

This program should achieve two objectives: 1. The prevention of home breakdown, throught the often preventable stress on the family presented by the retarded child; with a related decrease in the rate of institutionalization. 2. Supervision of the retarded individual in his assimilation into the community; with a related prevention of community problems and an improved handling of community problems should they arise.

Adequate services in this line would require, as a minimum, two social workers fully trained and competent in social work techniques. We now have in training, Miss Cummiskey who will be an excellent person to initiate such a program. She should have the help of another social worker to continue and/or extend this program. In addition to this and working under them we could definitely consider the On-Service Training of one or two untrained workers.

It is generally felt that specialized workers in the field of retardation are necessary to adequately put across this type of program. The utilization of other personnel such as Liaison Teachers and Public Health Nurses, is a possibility, but the use of such personnel would be effective only if the key social workers mentioned above are behind it.

This type of program will necessarily be closely integrated with the work of the Division of Child Welfare. This is presently possible, even with the gross shortage of staff in this Division. If this shortage of personnel in the Child Welfare staff is relieved (and it must be sooner or later) gratifying improvement of both

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Child Welfare Services and services to the retarded can be anticipated from close cooperation between the divisions.

IV. INSTITUTION

V. RECREATIONAL AND SOCIAL PROGRAMS IN THE COMMUNITY

Most areas I visited are establishing such functions for their retarded, and this is necessary and wise. Such services are provided through summer camps, occupational therapy groups, social activities, religious programs, etc.

These are best handled by Community Groups and Organizations, such as the A. R. C.'s and should be left in their hands.

VI. PROFESSIONAL TRAINING AND RETENTION OF STAFF

This is the key problem of any program whether the program be oriented to institutional or community type services. Key staff who are highly trained and highly intuitive to human needs are indispensable. This required adequate salaries for recruitment, and, what is even more important, adequate salaries for the retention of such staff.

To maintain the vitality of a program such as this it will be necessary to develop a well organized, continuing Training Program. At the present time one would see this being carried out at the following levels: (a) Federal Mental Health Grants can be used for training of Social Work Personnel. (b) Institutions such as the Southbury Training School in Connecticut would, I am sure, be glad to cooperate in training key staff personnel for us. (c) The facilities of the institutions

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and key staff personnel can be utilized for training of persons at the undergraduate level. (d) Teachers for Individual Advancement Classes should be selected from experienced teachers, and adequate summer school courses are available for their further training. (e) Teachers for the Day Training Class program can be trained in our present Day Training Class, this being supplemented by summer courses.

VII. RESEARCH

This may sound fanciful, however, its innate logic cannot escape us. The ultimate solution to the problem of mental retardation will come only from research. This is especially true in reference to the biological processes involved in the development of the human embryo. However, much remains to be known regarding the psychological, educational, social, and cultural aspects of this condition; and in these aresas of study Prince Edward Island presents unusual opportunities for research.

It has been well proven that the cost of research is more than returned by the vitalizing effect it has on any community or institutional programs.

It therefore seems sensible that for every dollar expended by the Provincial Government in this field an additional 2 or 3 cents be set aside for research. Necessarily, this will take some time to build up a usable fund. However, one could visualize that in a few years there would be sufficient monies to attract research personnel. With such personnel here, it would be quite possible to derive further research funds from such sources as the Federal Government Research Grants and various private foundations.

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VIII. LEGISLATION

Looking back on my tour it appears that I have paid insufficient attention to the legislation necessary to make such a program as this feasible. I am now attempting to overcome this defect by securing copies of legislation from various sources, however, this will not be at hand until after composition of this brief. Consultation with others more competent in the legislative field should be secured.

As a tentative breakdown of the necessary legislation, we should concern ourselves with the following areas:

(a) Registration - Registration of the mentally retarded should be obtained from physicians, clinics, parents, etc. This would provide an invaluable survey of this immense problem.

(b) Guardianship - Some legislation regarding Provincial guardianship of the retarded individual is necessary to protect the child and/or adult individual in case of calamity to the family. And, also, to give the staff of the organizations concerned with retardation, the necessary responsibility for working out an appropriate program for the retarded individual.

(c) Provision for a boarding out program, similar to that now enacted for our mentally ill population.

(d) Educational - Either of the "permissive" or "mandatory" type, that is, legislation either enabling or requiring the local school boards to provide adequate services for the retarded population where a need for such services exists.

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IV. INSTITUTIONAL FACILITIES (referred from Page 16)

Despite the increasing emphasis on community services, an institution remains necessary for a certain small proportion of our retarded population. Institutional services will have to be provided on the following levels:

1. Residential care of the severely retarded.
2. Residential care of transitional cases.
3. Day care programs.

CONSIDERATIONS REGARDING INSTITUTIONAL CARE

1. Residential care should be provided for only those who cannot be properly cared for in their own home or in a suitable foster home.
2. The institution must be oriented to the development of the individual to the maximum use of his potential. This will involve not only the establishment of a satisfactory emotional climate in the institution, but also extensive use of occupational therapy and industrial therapy. These might be provided in association with the programs now being established at the Riverside Hospital, and also by the use of Falconwood Farm.
3. The institution should be designed to approximate a normal home situation as closely as possible. This will involve consideration in planning the physical plant of the institution, and especially in the planning, selection and training of staff.
4. Active recognition and prevention of isolation of the institution from the community is necessary and should proceed along lines outlined elsewhere.

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5. The care of the low grade, non-trainable, retarded individual represents a humanitarian problem that must remain high on the list of public responsibilities.

6. The institution should serve as a hub for this whole program.

ADMISSION POLICY

Admission Board

An Admission Board should be set up consisting of personnel from the psychiatric, psychological, social work and pediatric fields; with representation not only from the Department of Health but also representatives from the Division of Child Welfare and/or other Social Agencies.

This Board alone should be responsible for admission and discharge from the institution.

Criteria for Admission to Residential Care

1. The Severely Retarded

Those retarded of low trainable or non-trainable levels whose care demands nursing facilities beyond that of the home.

2. Transitional Cases

(a) Those "retarded" who do not have a home or who are from an unsuitable home, and require transitional care leading to foster home placement.

(b) Those "retarded" who place an inordinate emotional strain on the home either towards parents or siblings, and who for this cause require temporary removal from the home, or

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(b) Those "retarded" who place an intolerable emotional strain on the home either towards parents or siblings, and who for this cause require temporary removal from the home, or

2. Transitional Cases (Continued)

transitional care leading toward foster home placement.

(c) Those "retarded who require temporary placement in the institution for emotional rehabilitation and/or social readjustment - e.g. delinquent retardates.

(d) Those "retarded" who requre temporary placement to afford holidays for the parents, or to relieve the home in case of an emergency brought on by sickness or other misfortune.

It is recommended that at least one-third of the bed capacity of the now proposed institution be reserved for cases of "transitional" nature. This will do much to (1) Keep the institution oriented toward achievement, and (a) Break down the potential isolation of the institution from the community.

Those "educable" children coming under this group should be serviced educationally by the special classes in the Charlottetown school system. Such a situation will require negotiations with the Charlottetown School Board.

DAY CARE PROGRAM

Many "retarded" children and adults, can be maintained at home if they are exposed to a program during the day which is oriented toward their level in occupation and/or recreation. It has been extensively shown that such a program of day care, with the child or adult staying at home through the night, provides an excellent method of handling even the severely retarded.

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As well as providing an excellent service to the "retarded", the provision of this type of program has other advantages.

(a) By thus serving the one-fifth of the Island's population in the Charlottetown area the expense of the total program would be considerably reduced, as there would be less demand for institutional beds. (b) This type of program will do much to counteract the tendency toward isolation of the institution from the community.

In the setting up of such a program service organizations should be relied upon to provide facilities for transportation of the individuals to the institution.

PHYSICAL PLANT

Operating on the frame of reference of the proposed 20 bed institution postulated to me before my tour, the following points should be made:

1. Already the demand, even on the extremely limited admission policy outlined above, exceeds 20 beds.

2. The ideal of an initial 20 bed unit should still be retained as this is an excellent size for one unit.

3. The "Cottage Plan" of units based on a home-like building with a bed capacity of 20 is undoubtedly the superior type of physical plant. This appears to have little economic disadvantage, and in getting away from the large dormitory type of building the humane aspects of the institution are greatly enhanced. Such a well designed physical plant reflects immediately in the increased personal welfare of those for whom the building is provided. The increased administrative problems posed by such a plant are more than compensated for by the benefits given the children.

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4. For ease of administration and for provision of auxiliary services such as laundry, the institution could be placed close to Riverside Hospital.

5. The dining room in each individual cottage is an almost indispensable asset in the training and habilitation of the retarded. Centralized dining room facilities should, therefore, be avoided. However, it would appear from my contact with cottage-type institutions at Southbury, Connecticut and Vineland, New Jersey, that the individual kitchen placed in each cottage provides insufficient training opportunity to merit its inconvenience. These institutions are working toward a central kitchen despite a very definite bias in years past to the individual cottage kitchen. This being so, it would seem wise that prepared food be provided from the already adequate kitchen facilities at Riverside, at least for this initial unit.

6. It is self-evident that the cottage should be a one-floor type. This gives the cottage itself greater flexibility, enabling the staff to care for any type of mentally retarded individuals therein, whether they are ambulatory, on wheel chairs, or bedfast. This type of flexibility is particularly necessary in our first unit as it is difficult to foresee just what type of patients we would wish to have there in some 5 to 10 years' time.

The second advantage of the one floor plan is that it provides much in the way of safety for the patients This is especially true in case of fire, but is also pertinent when one considers that a quite considerable portion of the persons cared for there will be subject to epileptic seizures.

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Although the one floor plan is womewhat more expensive than a two storey building, when the additional capital expenditure is spread over the next 50 years, the additional amount becomes quite insignificant in relation to the advantages gained.

7. The design of our initial unit which will necessarily house a wide range of types of persons with retardation, of many ages and both sexes, will pose a very neat problem in architectural arrangement. This will also call for a quite complex staffing arrangement. However, these will not be insurmountable.

8. Professional staff must be included in planning architectural design for the building.

9. There should be a master plan for the whole plot envisioning a minimum of three cottages and a maximum of five. This master plan should include appropriate landscaping, driveways, walks, etc.

10. Play room space, indoor and outdoor, must be provided. It is felt that sufficient play room space or rainy days should be provided in the basement. In the upstairs dayrooms, and in the basement playroom , dividers for partial separation of groups, should be included.

11. MIscellaneous, the plan should provide definite separation of dormitory and dayroom space. There should be outdoor garden space. Room should be provided for sewing machines, washing machines, and dryers for emergency use, and also to provide a"home-like" touch. There should be large bathrooms with at least one water closet for five patients. Tile walls and a terrazzo floors in the dormitory offer the best solution for a practical yet attractive room.

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12. Design of the cottage will necessarily include space for Day Training School facilities, and for Day Care facilities.

13. Office space for the personnel of community oriented services should be included.

STAFF

In the initial proposed unit the necessary staff will be quite heavy. This is dictated by two factors, (1) The wide range of problems that will be housed therein, and (2) Necessary provision of Administrative staff.

I would immediately visualize as key staff who should be started on training immediately:

1. A Social Worker - Miss Jacqueline Commuskey, B.A. has already been started on training for this.

2. A Registered Nurse with personal characteristics suited to this field, who (if she can be found) should spend some 6-8 months in Southbury Training School. Such a person will be necessary to supervise the physical care of the patients.

The administrator of the institution could come from either of these two levels depending on who would seem best suited. Certainly such an institution, however small, must have a head to handle the families of patients, public relations for the institution, and other problems as they arise.

Other staff will be necessary to put the unit into operation.

1. Cottage Parents - Two sets of husband and wife teams, one for the day and one for the swing shift. These should be warm, loving people, they

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need not be professional, but they must have a great capacity for human warmth and understanding of the patients. It is, therefore, essential that the final decision on personnel employed for these positions rest at the professional level.

2. Psychiatric Attendants - Male or female, one to cover the night shfit and one for the day care of the infirm.

3. One Supervisor of the Day Care Program.

4. One Day Training Class teacher.

ON-SERVICE TRAINING

This will be provided initially by the child guidance team, the specialist Social Worker, and the specialist R.N. This will need to be quite extensive, and will necessarily come under the supervision of persons who are well oriented and well trained in "Individual Differences."

PROFESSIONAL STAFF

Consultants to the Institutions:

1. A Pediatrician
2. The Child Guidance Clinic Team
3. Speech Therapist

Home Strengthening Services

1. Key staff Social Worker mentioned above.
2. One additional trained Social Worker.

As already mentioned, the necessity of using untrained social workers will need to be considered; as should also the feasibility of utilizing "Home Teachers" in this type of role.

need not be professional, but they must have a great capacity for human warmth and understanding of the patients. It is, therefore, essential that the final decision on personnel employed for these positions rest at the professional level.

2. Psychiatric Attendants - Male or female, one to cover the night shift and one for the day care of [illegible]

3. One Supervisor of the Day Care Program.

4. One Day Training Class teacher.

SERVICE TRAINING

This will be provided initially by the guidance team, the specialist Social Worker, and the specialist R.N. This will need to be quite extensive, and will necessarily come under the supervision of persons who are well oriented and well trained in "Individual Differences."

PROFESSIONAL STAFF

Consultants to the Institutions:

1. A Pediatrician

2. The Child Guidance Clinic Team

3. Speech Therapist

Home Strengthening Services

1. Key staff Social Worker mentioned above.

As already mentioned, the necessity of using trained social workers will need to be considered; as should also the feasibility of utilizing "Home Teachers" in this type of role.

Order of Development of Program

I am not unaware of your request for my outlining a possible sequence in which this program might be developed. I have struggled a bit with this, but would prefer to postpone placing it on paper until such time as the thoughts herein are more fully developed; and until I have some idea of the reactions to these suggestions.

Such a program will necessarily involve years of development to bring it to fruition. I shall remain ready to present an outline of such a sequence for you at a later date.

For the present, I would note the equal or greater importance of the Educational and Home Strengthening aspects of this program, in comparision with the importance of its Institutional phase.

CONCLUSUION

As I look back on the many words used to convey to you a survey of the problem of "retardation" and its needs, I cannot help but be aware of the fact that this program may be regarded as impractical and idealistic.

Nevertheless, when we think of the 3,000 members of our small Island Society who are at present suffering from our neglect we must realize that it is well past time that we did get concerned about this problem.

We must also consider the possibility that it is really we who are the "socially incompetents"; we, supposedly intelligent persons, who can frustrate children of low learning ability by exposing them for years to ordinary classroom procedures; we who, at times, derive satisfaction from teasing them; we who are blind to the major stres-

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supposedly intelligent persons, who can frustrate children of low learning ability by exposing them for years to orthodox classroom procedures; we who, at times, derive sadistic satisfaction from teasing them; we who are blind to the major stress-

ses that such persons place on their parents and homes, stresses caused in large part by our own mishandling of the problem. It seems indeed, that it is we who have been irresponsible; and it is certainly we who are the losers. Having sown the wind we reap the whirlwind, in unhappy disturbed individuals; in an incrasing burden of Multiple Problem Families; in an unproductive group of workers called the "no-goods"; in distressed families faced by distressing problems with their retarded sons or brothers, daughters or sisters.

Also in the light of present knowledge, we must appreciate the fact that while it is only by the sheerest of coincidence that we have been blessed with children of normal intelligence, others equally suited for this happy state by heredity, achievement and worth, are left by us with little or no help in dealing with the staggering problem presented by their "retarded child."

In view of all this we must conclude that such a program is neither "impractical" nor "idealistic". The problems presented by "Mental retardation" are very extensive and very, very real.

In our attempts to resolve these problems let us not lose ourselves in the natura satisfaction resulting from the erection of large, imposing, even well equipped (albeit usually understaffed) institutions; but let us also concern ourselves with the less glamorous task of providing educational opportunities, and an adequate well trained staff to meet the basic personal needs of our "retarded children" and their families. Then, and only then, will we be able to significantly alleviate the mal-effects of this widespread condition.

Yours truly,
M.N. Beck, M.D.

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Yours truly,

My Lord Chief Justice
and Members of the Royal Commission

The Provincial Council and members of the Catholic Women's League of Prince Edward Island wishes to place on record their concern for the health and well being of the Canadian people in general, and of the citizens of this Province in particular.

It is their considered opinion that any scheme of Health Services should be comprehensive in the fullest sense of the word, and should not discriminate in any way against any form of illness - physical or mental.

They heartily endorse the brief being submitted by the Prince Edward Island Division of the Canadian Mental Health Association and would respectfully urge the members of the Royal Commission to include in their recommendations to the Federal Government the proviso that all forms of illness - mental and physical - should be covered on an equal basis by any Health Plan which may be introduced by the Government of Canada and/or other agencies.

Respectfully submitted,

(Mrs.F.J. Steele)
Provincial President
Catholic Women's League

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Respectfully submitted,

Charlottetown
Prince Edward Island

Canadian Mental Health Association
Prince Edward Island Division
Charlottetown, P. E. I.

Dear Sirs:

Many thanks for a copy of the survey prepared by your society.

As you know, the Federated Women's Institutes of Prince Edward Island is an organization of rural women with a membership of four thousand who belong to three hundred branch Institutes situated in all sections of the Province - our motto, "For Home and Country".

Although the Women's Institutes are not considered to be an health organization, yet a portion of their program is devoted to the study of current health problems. The Board of Directos is pleased to note that some of the areas of concern dealt with in your survey are those of which the Institutes have long recognized as health problems in homes, communities, and schools. It is a real satisfaction to know that these phases of mental and emotional disturbances are being brought to the attention of the authorities under the names of those persons most qualified in our Province to understand them. The following are of particular interest to our organization.

Child guidance centres

Improved child welfare programs

Extension of mental health services to school children

Improvement of services to the retarded

Establishment of treatment centres for alcoholics

Improved housing and proper diets in the field of geriatrics

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Establishment of treatment centres for

Improved housing and proper diets in the field of pediatrics

It is the earnest desire of the Women's Institutes that this survey be presented to the Royal Commission on Health Needs in Canada when it sits in Charlottetown. If this is done, our organization should particularly like to see emphasized the great need for mental hospitals to be brough under the Hospital Services Commission in a like manner to the general hospitals.

Yours very truly,

(Signed) Lois (Mrs.J.L.) Dewar

President of Women's Institutes
of P.E.I.

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[illegible] [illegible]

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(Signed) Lois (Mrs.J.L.) Dawes

President of Women's Institutes
of P.E.I.

The Royal Commission on Health Services

Gentlemen:

The Prince Edward Island Teacher's Federation has reviewed with interest the Survey of Mental Health Needs (1961) prepared by the Canadian Mental Health Association. Several of our most active members have been involved in the composition of this survey, and a majority of our teachers participated in the compilation of some of the statistics contained therein.

We would go on record as endorsing this survey and its recommendations, particularly those having to do with Mental Health in the school.

Respectfully submitted,

Prince Edward Island Teachers' Federation

(Anna K. Riley)

General Secretary

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Respectfully submitted,

Prince Edward Island Teachers' Federation

(Anna N. Riley)

Prince Edward Island Divison
Canadian Mental Health Association
Box 785
Charlottetown, P. E. I.

Gentlemen:

We have examined statements prepared by your organization relative to problems associated with mental health in this province. First of all we would commend the very thorough examination which your group has made of these problems. Next we would concur in your views that mental health is a matter of very great importance and one which deserves the attention of all concerned with the general improvement of health services.

The Prince Edward Island Federation of Agriculture is pleased to endorese the general representations being made by your group to the Royal Commission on Health Services, and trust they will receive its careful consideration.

Sincerely yours,

(Signed) J. L. Dewar

Secretary

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The Royal Commission on Health Services

Gentlemen:

The Prince Edward Islnad Command of the Royal Canadian Legion has for many years been actively interested in the problems of Mental Illness and Mental Retardation.

Since 1955 our Charlottetown Branch has sponsored and supported a Day Training School for Trainable Retarded Children in the Charlottetown area. Many of our branches have been actively engaged in the various volunteer and fund raising activities of the Canadian Mental Health Association.

At our annual Provincial Convention held in Souris on September 9th of this year the following resolution was unanimously passed.

Whereas the Federal Government has appointed a Royal Commission to enquire into the "existing facilities and the future need for health services for the people of Canada, and the resources to provide such services, and to recommend such measures...as the Commissioners believe will ensure that the best possible health care is available to all Canadians"

And whereas this Commissioner will be holding public hearings in this province in the month of November,

BE IT RESOLVED THAT:

The Prince Edward Island Command of the Royal Canadian Legion present a Brief to this Commission regarding their attitudes on all health matters, with due

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RE IT RESOLVED THAT:

The Prince Edward Island Command of the Royal Canadian Legion present a Brief to this Commission regarding their attitudes on all health matters, with due

attention being paid therein to the major Health Problems of Mental Illness and Mental Retardation with which this Command of the Canadian Legion has been actively concerned over the past number of years."

Due to pressure of time we have been unable to carry out the full extent of this resolution. We would, however, implement one of its main concerns by going on record that we support and endorse the recommendations and principles contained in the Submission to your Commission by the Canadian Mental Health Association.

Respectfully submitted,

J. Hamilton Douglas, Prov.
President

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J. Hamilton Douglas, Pres.

---EXHIBIT NO. 34: Brief of Canadian Mental Health Association, Prince Edward Island Division.

MR. PEAKE: Gentlemen, we would welcome any discussion on this brief, and we will attempt to answer any questions among the delegation here.

THE CHAIRMAN: Do any of your associates wish to add anything by way of explanation or comments at this time?

DR. BECK: Perhaps I could say, Mr. Chairman, as chairman of this scientific planning committee in preparation of this brief, that for a period of two years on Prince Edward Island we had, I think, unusually adequate psychiatric service. We had five psychiatrists for a population of 100,000 people, which is somewhat unusual, and the survey relied on that two year experience heavily, and we projected figures from that concrete experience to what we thought might be adequate services.

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MR. HALL: Mr. Chairman, it may be that the survey, in part at least, was written on the assumption that reader had knowledge of the existing situation in Prince Edward Island, which may not apply to the members of the Commission, and in particular I was thinking of Section 6 which appears on pages 23 and 24. I thought it might be well that the present service nature might be elaborated upon in regard to the recommendations set forth.

DR. MALONEY: Well, this chapter, Section 6 -- or rather this section deals with two things. One is the method by which the psychiatrist would be paid. Now, I would like to make clear at this time that this Association is only interested in recommending that the psychiatrist or the method by which psychiatry or the psychiatric patient pays his bill be the same as the general physical bill that the medical bill is paid. We are not advising any particular way. We merely want that psychiatric illness or mental illness be paid for in the same manner as all other illness. We are not advising any particular way, merely that it be the same as the general way of medicine. That is the meaning of one, two and three. This was the recommendation at that time to the province.

On page 24, the provision of psychiatric wards in general hospitals, this again is in line with our recommendation that mental illness be not thought of or acted upon as being any different from any other type of illness, and that is the reason why we wish to have the psychiatric provisions in our hospitals.

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Each year more and more psychiatric patients are admitted. This is a thing that may seem surprising at first, because among people we often find the idea that many psychiatric patients are very distrubed and they need restraint, etc. This is not true. It is only a very small minority of patients who need custodial care, and a very small number that would need restraint. I think this grew up from our culture in the days when the village idiot was teased. This is a misapprehension that we people generally are under, that a high number of people are not suitable to be treated in a general hospital.

No. 2 also is a move toward making it the same as any other hospital, not where the children walk around in a big detour; it is visited the same as any other hospital is visited, so they familiarize themselves with the mentally ill and accept them. I think the basis of treatment is that the mentally ill should not be allowed to retreat from the world. They should not be allowed to make this retreat a final one; they must be kept in contact with reality, and this is best done in the concept of what is a general hospital, although there will be a few patients who have degenerated and who are best kept in a custodial type of institution.

THE CHAIRMAN: Now, the criminally insane. For instance, a person is found not guilty in a court but insane, and by law he must be kept in custody. As far as Prince Edward Island is concerned, have you any place of custody for such here?

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DR. BECK: Mr. Chairman, we do have a small number of such persons at Riverside Hospital, our mental hospital. Our experience has been that these type of people can be cared for in the hospital setting. The ones that we have had we can care for in the hospital as a hospital rather than in the hospital as a prison. In other words, the patients we have had in this category we haven't had to keep closely confined. We have one such problem on our hands right now, but fortunately we don't have any that require incarceration. This problem hasn't presented itself to us as yet, although it might. If we had the facilities I think it would be a mistake to turn the hospital into a prison. I think we should use other facilities in other provinces for that type of thing.

THE CHAIRMAN: Then you have another facet of the same problem, the person who finds himself in court and, as you know, the magistrate or the judge -- provision is made whereby this person may be sent to an institution for a period up to 30 days for observation, to report back to the court whether or not he is fit to stand trial. How are those people handled?

DR. BECK: There again they are handled the same way, and there again we ask that the court sends them to us as a hospital rather than a prison.

THE CHAIRMAN: In that context it is perhaps easy to follow because they have not been convicted or dealt with.

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DR. BECK: Yes.

THE CHAIRMAN: Supposing the report is that that person is not in a fit condition to stand trial. What becomes of him then? Because he can't be released, you see; the offence is still standing over his head, he is not fit to stand trial. He eventually comes back to the court and the court makes the decision he is not fit to stand trial.

DR. BECK: Then we have a Governor's warrant under which he is detained. Then again we detain him under a hospital setting and not a prison setting. Although this problem, as I said, hasn't caused us any serious problem to date, I can see that it might in the future.

THE CHAIRMAN: Have you any close custodial facilities for a person of that kind or a person who might come into that category?

DR. BECK: No, we don't, and with the trend within the hospital our facilities are getting less and less custodial and less and less incarcerating. For instance, in Riverside Hospital there are no screens at present on any of the walls. In the main building there are two open wards at present, and our incarceration measures are less and less effective.

THE CHAIRMAN: You appreciate that insanity as an offence may be simulated up to a point, and it may be that a person is committed to your hospital where there are no screens on it. I am just wondering how it works in practice.

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DR. BECK: It is working all right in practice, it has worked all right in practice. I know of five criminals in this category, and with those it has worked quite well in practice.

THE CHAIRMAN: Then there is the sexual psychopath.

DR. BECK: The sexual psychopath is not referred to our facilities primarily. This comes under the Canadian Criminal Code and they are taken to a penitentiary which takes them off the island completely.

THE CHAIRMAN: You haven't a long-term institution on the island?

DR. BECK: No.

THE CHAIRMAN: Where do they go to now? The new place at --

MR. PEAKE: Dorchester.

THE CHAIRMAN: The new institution in Nova Scotia?

MR. PEAKE: Springhill.

THE CHAIRMAN: Is that what is called close confinement or open door?

MR. PEAKE: It is more of the open door.

COMMISSIONER BALTZAN: Mr. Chairman, just a few questions in consideration of this elaborate survey. I would like to make one or two inquiries about certain estimates which you may or may not have. No. 1, what proportion of the general population needs psychiatric care only? When one reads out of context this very elaborate discussion of so many

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needs for so many people one gets the impression that this is an overwhelming thing and sometimes there are too many people and some of them are queer. There have been studies like that made in other countries, and do you happen to have a guesstimate of the general population that need only psychiatric care?

DR. BECK: This is a very difficult thing to do. As you have already stated, it can at best be a guesstimate. The generally accepted feelings along this line or the generally accepted figures -- and this is difficult to substantiate -- that possibly a third of the people who appear at doctors' offices are suffering primarily from psychiatric conditions and another up to 50 per cent have psychiatric overtones involved in their physical complaints. That is one way of getting a guesstimate. There was a survey done by the University of Parnell where they did a spot check of every 30 persons through the community, and their people figured, if I am not mistaken, close to 40 per cent of the people they checked had some type of psychiatric disability.

Now, going back again, guesses -- I am sure that some of them we wouldn't call illness. When you get into psychiatric illness you get into a matter of degree. Some of us have headaches and some of us have upset stomachs, but it doesn't upset our lives.

COMMISSIONER BALTZAN: You refer to the people that go to visit doctors in their offices or call doctors. If I remember the literature, about

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1940 in England Cutler and others estimated that of the number of people who go to see doctors one-third of them go for non-organic disease, and recent literature in the United States, if I am up to date, of course, shows that 10 per cent of the people who go to visit doctors' offices have functional or non-organic disease. What is your situation here?

DR. BECK: In my own experience in general practice I think that this figure was perfectly valid, the figure of a third, from my own experience.

COMMISSIONER BALTZAN: A third which way?

DR. BECK: A third organic. I think that people that have both physical and organic will then go up to 50 per cent or 60 per cent.

DR. MALONEY: I may make one or two comments on that, Dr. Baltzan. One is that I would agree with those figures that approximately a third of our symptoms or disability due to mental illness alone, approximately a third are combined mental and organic ilness, and in this case the patient -- I think it is perhaps by mutual consent in the milieu in which we live -- that the patient comes with an organic complaint but is not primarily interested in the organic complaint but in something else, and it is up to the doctor to find out the complaint.

The second thing I would like to comment on is if such a recommendation were put into effect, that is the recommendation that we make that psychiatric ilness or mental illness be thrown into the general pot and treated and payment made as for organic illness,

[illegible] Ingland Cutler and others estimated that of the number of people who go to see doctors one-third of them go for non-organic disease, and recent literature in the United States, if I am up to date, of course, shows that 10 per cent of the people who go to visit doctors' offices have functional or non-organic disease. What is your attention here,

DR. BROCK. In my own experience in general practice I think that this figure was perfectly valid, the figure of a third, from my own experience.

COMMISSIONER BAYLZAN. A third which ways

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this would not mean a large increase in the medical services for the simple reason that most of these are being taken care of under the guise, by mutual consent, as I said, of organic illness. Many of the patients with colitis, asthma, etc., we now list them under the organic symptom which manifests the mental disability.

COMMISSIONER BALTZAN: Leading up to the question about the shortage of psychiatrists and need for more psychiatrists, my next question would be how many of those with emotional and mal-adjustment complaints need specialist's care. That is the fully trained psychiatrists. Perhaps I could make this all one question. Do you agree that the vast majority of the emotionally disturbed and functionally disturbed, mal-adjusted, can be treated by the non-specialist, the modern trained general practitioner? I could quote that it has been said, and it is written in the literature that 90 per cent of these do not need psychiatrists, they need good doctors.

DR. MALONEY: Yes, I agree with that. I would agree that the majority of these can be treated by the doctor who sees them and that only a minority need be referred to the psychiatrist, and I think it is specially true if the doctor has enough time. That is the main factor in dealing with these people, that it requires time.

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DR. MALONEY: Yes, I agree with that. I would agree that the majority of these can be treated by the doctor who sees them and that only a minority need be referred to the psychiatrist, and I think it is specially true if the doctor has enough time. That is the main factor in dealing with these people, that it requires time.

DR. BECK: I concur with this, that the minority, I wouldn't put a figure on it at all, but the definite minority need psychiatric --

COMMISSIONER BALTZAN: Perhaps we could put it this way, that we do not need so much of more and more psychiatrists, but perhaps we need more and more of doctors to understand these problems related to mental disturbance?

DR. MALONEY: I think it would be a little bit better said, sir, that we need both.

COMMISSIONER STRACHAN: I was wondering if all patient care in mental hospitals were placed under an all-inclusive insurance scheme, is there any estimate made of how premiums for such insurance would be increased?

DR. BECK: This is a difficult question. In the first place, we don't know what the total premium would be. We will have a better idea when we come out with the costs of mental hospital care. I think the first point I would like to make here is that primarily any suggestion that professional services within mental hospitals be provided on the same basis as professional services in other hospitals, we are not talking about additional costs, we are talking about costs already being borne in one way or another. At the present time in the Riverside Hospital we have three psychiatrists, one of which is engaged in administration, and this leaves two psychiatrists whose services would be provided on a prepaid insurance basis. In a percentage way this

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should not make a very big dent in the total. If we are talking of hospital costs, the present cost of administration for running the Riverside Hospital, the budget is $600,000.00 a year.

THE CHAIRMAN: Have you the daily per patient rate?

DR. BECK: We don't have a patient per day rate which is valid sir, the reason being this, that up until this past year the provincial infirmary was also included in the Riverside Hospital costs. We did strike a figure in this, and I will look it up.

THE CHAIRMAN: That is the figure that was given here yesterday?

DR. BECK: Yes, this $600,000.00 figure, the actual cost is slightly higher than this, because in the administrarion of Riverside a lot of the costs, heat, electricity, maintenance, are hidden under the budget of the Public Works Department. I don't know if that answers your question or not sir?

COMMISSIONER STRACHAN: Possibly it is the best way it can be answered.

DR. MALONEY: I can tell you how you can get an answer for it. There are approximately 70,000 mental patients in hospital in Canada. What we need is a mental hospital run by governments though under the same system of accounting that all general hospitals do, and this states every item that goes from the time the patient arrives until he is taken home. Most mental hospitals keep their books in a different way. They have three or four departments.

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Maybe the person who runs the ambulance does not come under the budget of the hospital. For instance, here it is heated by the Department of Public Works. The Department of Agriculture have a farm, and contribute materially to the food used. If it were done in one hospital, then those figures could be used fairly well for the total population in Canada. In other words, if those hospitals went on the system of accounting that our general hospitals do, they could arrive at an exact rate.

THE CHAIRMAN: What is an average per day rate in a general hospital?

DR. MALONEY: You have that figure in the back of the brief yesterday. I think it is about perhaps $18.00.

COMMISSIONER McCUTCHEON: Dr. Maloney, are the recommendations that you make in this brief, are they supported by the Medical Association of Prince Edward Island?

DR. MALONEY: Very definitely sir, every one of them.

COMMISSIONER McCUTCHEON: In other words, can we take it that the Medical Association of Prince Edward Island, yesterday giving us figures as to the estimated cost of the plan, that they were proposing, that they were including mental illness in making up that figure?

DR. MALONEY: First to support our recommendations, that figure that they gave didn't include the cost of mental illness services for the

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reason that there is almost no place right now where you can get figures which will tell you what the cost of medical services to the mentally ill outside of hospital will cost, but it is expected in the next six months, with several inquiries taking place, in Winnipeg, and in the United States, you will be able to get a figure for that, but for the reasons that I was speaking of to Dr. Baltzan, the cost of the mental service hospital is not thought to be a big item, perhaps five or ten per cent.

DR. BECK: This is a figure that you will likely be given later from the Canadian Psychiatric Association. All I have is a verbal report. In the Halifax area they did a private study, a confidential study, and went to all the psychiatrists and asked them what patients they saw, their charges, and so on. In other words, they arrived at a concrete figure of the actual cost of the psychiatric services in the city of Halifax. Psychiatric services in the city of Halifax are at a pretty high level. They then took these figures and wondered what percentage of the total budget of Maritime Medical care, what percentage of the Maritime Medical care budget this would come out to, and it came out to less than one-half of one per cent.

THE CHAIRMAN: Do you think that the result of that study could be made available to the Commission?

DR. BECK: It will be made available to the Commission through the Canadian Psychiatric Association, sir, I understand, but we do have this experience that

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Dr. Maloney has talked about in Winnipeg and British Columbia, a rather comprehensive plan for some years, and the others in the States, and here again the figures, percentage-wise, are quite small, I am sure less than 5 per cent, and possibly lower than that, but it doesn't come to a very great financial problem, and I think the reason being that many of these patients are also being covered under medical physical diagnosis, rather than psychiatric diagnosis.

COMMISSIONER VAN WART: On page 2 of your white brief, at the top of the page, you are speaking about health insurance, and you state: " -- it should protect against such costs, --" and you go on to state: "-- on an out-patient basis, --". Now, do you visualize that including drugs which the out-patient needs to have to be treated at home?

DR. MALONEY: We were not thinking of that including drugs, other than the drugs that would be supplied to patients who have been discharged from the hospital and were continuing on treatment after discharge, but we were not thinking of the drugs for patients who had never been admitted.

COMMISSIONER VAN WART: Yes, I understand that, but one of the benefits would be that you would supply drugs to the patients who have gone through your clinics when they are at home?

DR. BECK: I think the simple answer is that we have not considered that particular aspect.

COMMISSIONER VAN WART: Well, that is one of the costly things of treating your out-patient

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mental cases, is it not, the cost of the drugs after they are discharged from your hospital? Have you given any consideration how that could be covered at all?

DR. MALONEY: No, we have not given any consideration to the cost of drugs to the patient who has not been in hospital. We have been assuming that we will be continuing what we are doing with those who have been in hospital. For those who have not been in hospital, we have not considered the matter of supplying them with drugs.

COMMISSIONER VAN WART: I am confining my question specifically to those patients who have gone through your clinic and who have been discharged, and must carry on drugs and report back periodically. Have you given consideration as to how they will get the drugs?

DR. MALONEY: In the medical brief yesterday, I think it recommended that patients who are unable to buy their own drugs should be supplied. Ones who were capable would buy their own.

COMMISSIONER VAN WART: That was in the extended plan, not the basic plan?

DR. MALONEY: No, it was not in the basic plan.

COMMISSIONER VAN WART: As I see it, that is one of the most difficult problems you are up against, is an out-patient on a continuing basis receiving the drugs that are necessary for the proper treatment. You have no suggestion how that could be

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DR. BECK: On our experience I cannot give figures. We have for the past two years been supplying discharged patients from hospital with the drugs they need. This we felt, and still feel, was first a valuable service to the patient, and secondly a valuable service to the government, as it kept the patients out of the hospitals. In the type of clinic practice which I am in, I have not run into drugs as a major problem, and the tranquilizers are costly, yes, but for the length of time we use them on an out-patient basis it has not been a major problem in the clinics. Dr. Therriault is here, and maybe he can speak to this.

DR. THERRIAULT: Mr. Chairman, and members of the Commission: the problem at Riverside was not as major as it might seem on the surface, because the drugs were being given to discharged patients. We were getting them at cost of course at the hospital, with various deductions probably up to 55 per cent, maybe more, and so the patients were getting the drugs where the cost of an individual drug might be from a quarter to a third, in other words, a pill costing 18 cents might be given to the patient for nothing at a cost of four or five cents, so therefore that cost would be considerably lower when you consider it on a retail basis. In private practice, it is a very costly item. Where you have to prescribe drugs at $25.00 to $35.00 a month for six months, it does go into money. However, one of the arguments that can be

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used against that is the fact that these patients who can be kept out of hospital, even at a cost of $180.00, are money ahead if they had to go into a mental hospital at the present time, that is Riverside, and pay $6.00 a day for 180 days, so it may level itself out. It may not be such a big problem as it appears although when the pharmacists present the patient with a $25.00 bill for my prescription, he seems to think it is insurmountable.

DR. MALONEY: I think what we would partly recommend is that the decision as to whether or not the drugs which would be supplied to these people should be the same decision as is made in the supplying of drugs to patients with organic illness.

THE CHAIRMAN: You recommend that there be some mechanism whereby a person who might suffer mental illness would be able to insure against that, and that is on the first page of your submission this morning, paragraph 3, where you say now is unable to insure against this eventuality, you think he should be able to insure against it. Would you include this item of drugs as one of those hazards to be insured against in the context of this paragraph?

MR. PEAKE: I would say again, on the same basis as they insure against any other illness.

THE CHAIRMAN: If you are accepting the program of the Medical Association of an overall coverage available to everybody at a premium worked out in some way or another, that we include the mentally ill as well as the others?

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THE CHAIRMAN: If you are accepting the program of the Medical Association of an overall coverage available to everybody at a premium worked out in some way or another, that we include the mentally ill as well as the others?

MR. PEAKE: Yes.

THE CHAIRMAN: And whatever expense that person was put to for his illness?

MR. PEAKE: Yes, we want mental illness in the same vehicle.

THE CHAIRMAN: And under the same umbrella coverage?

MR. PEAKE: Yes.

DR. BECK: We are having trouble with our hats this morning.

THE CHAIRMAN: No, as a matter of fact we are not able to recognize it as two hats. If we accept your general premise that mental illness is just another illness, where do the two hats come in?

DR. BECK: This is the trouble with our hat. Speaking of the Mental Health Association and approaching this problem from the separation, recognizing that there is a problem in a separating out mental illness from physical illness, this is a difficult complex problem, with tradition and actuality working against us. The main emphasis, I think, that this Association would like to make, is that this illness receive the same consideration as any other type of illness. If it is in drugs, that it be the same consideration; if it is in medical services, that it be the same consideration; if it is in hospital care, that it be the same consideration.

THE CHAIRMAN: Those that are unable to pay to have the premium, or whatever form of contribution

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might be determined, paid by the State?

DR. BECK: Yes.

THE CHAIRMAN: And those who are able to pay should have the privilege of doing so?

DR. BECK: Yes, and coming back to this hat of the Mental Health Association, the big thing here is that if these problems are treated equally under any plan that might be devised, that this may perhaps be the major thing that will eventually break down the stigma on mental illness, and on the other hand when mental patients have to pay their hospitalization, and other patients do not, this is a stigma against mental illness.

THE CHAIRMAN: So you want them all brought under the one program, whatever it might be?

DR. BECK: Yes, that is right.

THE CHAIRMAN: Do you go along then with the further recommendation of the Medical Association that how you determine those that are not able to pay, that is the means test, that is how you would determine those who are unable to pay the insurance premiums, or whatever it might be?

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DR. MALONEY: We represent the Medical Health Association, which is a voluntary organization and we do not wish to put views into their mouth which we do not think are representative.

THE CHAIRMAN: I quite understand, Dr. Maloney. I am not trying at all to involve you, but I think we are rightly concerned with this matter of expense and just how the thing would work out. You come forward with a proposition that you want mental illness treated exactly the same as any other illness.

DR. MALONEY: Yes.

THE CHAIRMAN: You want them covered by the same program?

MR. MALONEY: Yes.

THE CHAIRMAN: You say that those who are unable to pay should have the premiums paid for them.

DR. MALONEY: Yes.

THE CHAIRMAN: All I am asking is, how are you going to determine that class? Are you going to do it in the same way as with other illnesses?

DR. MALONEY: Exactly the same way, sir.

THE CHAIRMAN: Because I wanted to come to the recommendation that I find on page 9. At the foot of the page you are discussing the use of social workers, and you say, about the middle of the page, that the social workers' main functions would be to do social histories and also take part in treatment, and since there is a general tendency today to have the patient pay for services according to his income level, the social workers would also

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be responsible for assessing the patient's economic situation. Are you still supporting that position now today?

DR. MALONEY: That is what is occurring now. This is not what we recommend in the future. This is a statement of what the social worker has been doing under the regime we are now working under. Under the one we recommend the social workers' responsibility for assessing a patient's economic position would disappear, and it would go into the same assessment board that operates for all illnesses.

THE CHAIRMAN: I am quite happy to accept your explanation. It is not the way the paragraph in the section reads. It is future. Neither present or past.

DR. MALONEY: Well, let us say when this was written we did not know you were coming down here.

THE CHAIRMAN: Very well. I want to put the question very specifically: would you consider that to use a social worker to assess the economic situation would be a detriment to good social working?

DR. MALONEY: Yes, it would.

DR. BECK: May I elaborate on that question, sir?

THE CHAIRMAN: Yes.

DR. BECK: I think here we have to distinguish between the various goals of social work. If the social worker who is doing case work, which is akin to psychotherapy, has to do the economic assessment,

be responsible for assessing the patient's economic situation. Are you still supporting that position now today?

DR. MALONEY: That is what is occurring now. This is not what we recommend in the future. This is a statement of what the social worker has been doing under the regime we are now working under. Under the one we recommend the social workers' responsibility for assessing a patient's economic position would disappear, and it would go into the same assessment board that operates for all illnesses.

THE CHAIRMAN: I am quite happy to accept your explanation. It is not the way the paragraph in the section reads. It is future. Neither present or past.

DR. MALONEY: Well, let us say when this was written we did not know you were coming down here.

THE CHAIRMAN: Very well. I want to put the question very specifically: would you consider that to use a social worker to assess the economic situation would be a detriment to good social working?

DR. MALONEY: Yes, it would.

DR. BECK: May I elaborate on that question, sir?

THE CHAIRMAN: Yes.

DR. BECK: I think here we have to distinguish between the various goals of social work. I, the social worker who is doing casework, which is akin to psychotherapy, has to do the economic assessment.

this is a negative opinion. If we have a social worker who is working full time on this type of assessment, this would be a different matter.

COMMISSIONER GIRARD: Mr. Chairman, I have one question, and maybe Dr. Beck would answer it, or would like one of the nurses to answer. On page 44, section 12, No. 5, I see there is some concern about preserving the affiliation for nursing assistants -- affiliation programs in psychiatric hospitals. I would like to know if there is an affiliation in psychiatric hospitals for student nurses, and how long is this affiliation?

DR. BECK: Here again Prince Edward Island is well servied, psychiatrically. For possibly two years now we have had an active affiliate program with the training schools in the various general hospitals. This, of course, is handled primarily by a full time person associated with the Riverside -- Miss MacLennan's training school. The psychiatrists participate actively in the lectures given, as do the social workers, the psychologists and nurses on the wards. It has been a very valuable program and very well received. It is about a twelve week course. It falls in with the twelve week block of other schools' program.

COMMISSIONER GIRARD: It is not only a course. It is also affiliation with practical experience with service?

DR. BECK: Yes, some 12 to 15 girls every twelve weeks come out of the hospital, live in a

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DR. BECK: Yes, some 12 to 15 girls every twelve weeks come out of the hospital, live in a

residence at the hospital, participate actively in the ward routine. The apprenticeship system is minimized.

COMMISSIONER BALTZAN: Just a little elaboration on that very same point. Are your psychiatric nurses a class by themselves? Are they specializing or taking special courses during their regular training to become registered nurses? Do you have a class of special psychiatric nurses who have not taken the full three years of the nursing course to become registered nurses?

DR. BECK: I think I can read into your question that you are thinking here in terms of the western provinces' background where they have fairly highly developed psychiatric nurses.

COMMISSIONER BALTZAN: Yes. I didn't want to mention it, but you know what I mean.

DR. BECK: On Prince Edward Island we don't have this type of system. What we have had historically at Riverside Hospital is a two year program of training psychiatric attendants, and they have never assumed the name "psychiatric nurse". They remain psychiatric attendant, although I must say these graduates have performed the role of psychiatric nurse, and performed it very capably, but we have never gotten into the political, professional problem present in other areas. At the present time -- and all of us are a little bit apprehensive about this -- this two year course has been dropped in favour of a one year course for training of

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nursing assistants, and we are a little bit apprehensive of just how this is going to affect our nursing program at Riverside, but we have to wait for experience to prove that.

COMMISSIONER GIRARD: Dr. Beck, do you have any male nurses on Prince Edward Island?

DR. BECK: At the present time we have none at Riverside Hospital. We have had them. We do have at the present time fairly adequately staffed nursing services at Riverside in many of our wards.

COMMISSIONER GIRARD: Can I pursue the question and find out if there are any male nurses outside of mental hospitals? That may not be exactly what we are talking about.

DR. MALONEY: No, there are not.

COMMISSIONER VAN WART: These girls, the twelve that come out on a twelve week course from the various hospitals, in Prince Edward Island, are they selected girls from the general hospitals, or is it obligatory that every girl as part of her undergraduate training shall go to the institution for training?

DR. BECK: This covers all the student nurses in the province.

COMMISSIONER STRACHAN: Under present circumstances and long-term geriatric care in the mental hospital, the financial responsibility could become a burden. How far do you go in the collection of accounts? Are lifetime savings used up to the extent that there is not enough left for the lifetime

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of the person -- to keep?

DR. BECK: The Hospital Act states this charge is not to impose a financial hardship on the patient, and the practice is in line with this: I have to answer your question specifically; if a person has money and is an older person her estate would be substantially used up -- or his estate would be substantially used up in the payment of this bill.

I would like to come across just a little bit in this question and state that the real problem in this charge is not the person who does not pay. Our administrative staff does not push the patient. If you don't pay, it is quite easy. Persons well off can afford the charge. It is the conscientious person of modern means that really gets caught by this $6.00 and $3.00 charge, and time after time I have seen this work to the therapeutic disadvantage of a patient.

COMMISSIONER FIRESTONE: Mr. Chairman, this brief from the Canadian Mental Health Association, Prince Edward Island Division, is very complete. I would like to congratulate Mr. Peake and his associates on the completeness of the survey, the specificness of the recommendations and the fact you have put a dollar figure covering all the recommendations you have made, which will be helpful to the Commission. You have also outlined your capital requirements and your other requirements. This is specific, and this is the kind of brief we are looking for, and that is most helpful.

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Therefore, I find, Mr. Chairman, that I have no specific questions as to the contents of the brief, and I would like to concentrate my inquiries on two general areas.

The first one referred to Dr. Beck's comment about wearing two hats. He realized as a result of the questioning that one runs a little bit into difficulty when you try to wear two hats because it suggests that there is a differentiation being made between ill health due to physical causes and mental ill health. I wonder whether this problem could not be resolved if you were to think in terms of the two sides of the same coin. The coin is ill health; one side is organic ill health and the other non-organic ill health. If you accept that approach, presumably, Dr. Beck, you can then say, since you are treating that ill health with its various causes -- you can develop one program to deal with ill health whatever its cause. Would this approach appeal to you?

DR. BECK: This would satisfy me to no end, sir.

COMMISSIONER FIRESTONE: If I may turn to the second broad area, and this question is addressed to both Dr. Beck and Dr. Maloney, I would like to pursue for a moment the subject of the economics of mental health, and I am emphasizing "health" rather than "ill health". I understand, Dr. Beck, you were talking of psychiatric disabilities and you were saying they are a matter of degree.

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DR. BECK: That is right.

COMMISSIONER FIRESTONE: How can we establish that degree of psychiatric disability which leads to economical losses either due to the inability to work or the ability to work less productively?

DR. MALONEY: Speaking for myself, I don't understand that question. I think if you could be a little more definite -- how can we determine the extent of psychiatric illness that leads to inefficiency and productivity, or ...?

COMMISSIONER FIRESTONE: I will be very glad to elaborate on the question a little further. A man comes to you and you decide he is ill. He suffers certain psychiatric disabilities. What degree of psychiatric disability must this patient have to be affected in his ability to work? In other words, he will not show up at work, he will miss a day, or when he goes to work he has a headache and he is less productive, or he shows certain symptoms which are not acceptable to his employer and he may get fired. You have turnever in the labour force and these are costs to the firm and to society, and we would like to be taught by you -- because we are all laymen, speaking for myself, anyway, -- we would like to understand what are some of the economic losses which a nation incurs due to mental ill health, because if we had an understanding as to what those losses are, we can then say, if we come forward with a program to deal with it, that it is going to be the nation's gain to deal with ill health, because if

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these mentally ill people can be cured they will be productive and it will cost us much more than it costs to restore their health. But before we can come up with such a program we have to understand how we can determine the economic impact of mental ill health.

DR. BECK: This is, I can readily see and determine from the expression on people's faces, a question you would like to have answered. It is also a question I would like to be able to answer. I am not sure that I can. My first observation would be this: that this is a unique approach to illness. Most illnesses we treat because people are sick, and we want to get them well. We treat people because they are sick, not because they are not productive. As a physician this is my primary area of concern. Returning to your primary question, we should speak not of mental illness but of mental illnesses, which gives us a very broad category to cover. Depressions result usually in a six week, three month, loss of productivity if treated, and in a one year to two year loss of productivity if not treated. Schizophrenia is the main problem in this connection. Schizophrenia is an illness which occurs usually when the person is young, in his teens -- late teens or early twenties. If this illness is not treated well, not treated early, it results in the loss of productivity over that individuals's entire lifetime. At the present time we have in Riverside Hospital some 300 chronic patients. I would estimate that

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of these 150 to 200 of them are chronic deteriorated schizophrenics.

Now, if these people had been treated well I think I could confidently state that the majority of them would have been productive. I can back this up to this extent, that in the past five years we have had relatively adequate treatment facilities at Riverside for our schizophrenics, and during that period only two of the patients admitted have become chronic patients.

COMMISSIONER FIRESTONE: Out of how many, sir?

DR. BECK: I couldn't give you an exact figure, but it would be 100 to 200. It would be more than 100. I think this is a concrete answer to the answer of productivity. I think there are many cities in the community who are schizophrenic and relatively unproductive, vagrant drifters, but this kind of thing I haven't any figures on. But if we could get these people and treat them I think we could help them in productivity.

There was a book written at one time, "Thank God we are Neurotic". There was an article in Maclean's a couple of weeks ago talking about work addiction and some psycho-neurotics are more treated than un-treated. Generally psycho-neurosis decreases a person's productivity, and with treatment they become more productive, and if not more productive certainly happier citizens.

COMMISSIONER BALTZAN: I am getting much

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COMMISSIONER BANTZAN: I am getting much

interested in the normal people and their needs than some of those who are receiving consideration this morning.

Arising out of the very recent conversation, I would like to know from you if a person who does not like his work or his boss, is he a sick, disturbed, or inadequate person?

DR. BECK: Here again this is the kind of difficult assessment we have to make in psychiatry, and in order to make your assessment you have to know what is the boss like, or project from what he tells you about the boss and then work back on your patient and try to find out if he has a pattern of rebellion against authority, and if he has and this is significant in disturbing his life pattern and because of it he is moving from job to job and he can't stay in any job for any length of time because of his rebellion against authority, then I would call him sick. If he doesn't like all bosses, then he is very likely sick.

COMMISSIONER BALTZAN: Conversely, does work which people do not like or enjoy make people sick?

DR. BECK: I would answer that yes, and they are having an adjustment because of this.

MR. PEAKE: I would like to suggest in answer to Mr. Firestone's question as to figures -- and I am associated with the Department of Veterans Affairs, under the War Veterans Act it allows for awards to indigent veterans. Under the age of 60

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MR. FRANK: I would like to suggest in answer to Mr. Firestone's question as to figures -- and I am associated with the Department of Veterans Affairs, under the War Veterans Act it allows for awards to indigent veterans. Under the age of 60

years a medical assessment is required whether that person is able to work or not, and we have many World War II veterans who are under the age of 60 years and have been medically assessed as permanently unemployable under the terms of the Act or incapable of maintenance. Some of them are psychiatric cases, and I think the Commission might be able to obtain information from Ottawa as to the productivity, loss of productivity. I have one particular case in mind where this fellow qualifies on all grounds except that is he capable of productive employment. Is it the best thing to give him $80.00 or $90.00 a month or should he be treated to become a productive person. It is a question of who is helping him, whether we should support him or whether we are putting another leach on the national economy.

COMMISSIONER FIRESTONE: Thank you, Mr. Peake for your suggestion and we will follow it up in Ottawa.

DR. MALONEY: I can't answer the question of Dr. Firestone's, but I think it can be refined further. If you take the total loss of productivity in a country you can then split off immediately your 70,000 people who are in mental hospitals, and you know what it costs, and then you take what remains. There is a small margin at first, of people who are merely depressed, tension headaches, but who are carrying out a good job, and you are left with this middle core, and this is the core towards which the question must be focused.

Finally, the last comment I would make is

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this. If we had a program in mental illness, the treatment of the stuttering child, the child who cries all the time, the child who wets the bed at night, this is where we can attack the problem. If we had such a program, at first our costs would be high, because we would be carrying this program plus the backlog of the people, but when that backlog disappeared then it is our opinion that the increased benefits from productivity with this increased program would more than offset the cost of the program.

COMMISSIONER FIRESTONE: In other words, you are putting a mental health program for the young in the same category as the dentists are putting in a fluoridation program, and as a result we expect to have healthier people, whether healthier teeth or healthier minds.

DR. MALONEY: Yes, and this is the most important part of these recommendations.

DR. BECK: I would add that I think the Mental Health Association is going to try to attack for you this very problem of productivity. They have a team working now, and hope to have a more definite figure for you in the spring.

There is another thing. I am a child psychiatrist. Let me pose this question to you. You take a child who has an I.Q. of 120 with a reading disability which is not detected in the early school years, and this child doesn't get beyond grade 8 and seldom completes grade 10. We have ten per cent of our school children who fall into this category.

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How do we estimate the loss of productivity of that child on a long-life basis?

COMMISSIONER FIRESTONE: Well, Dr. Beck, you have not answered our question very helpfully, and so has Dr. Maloney and so has Mr. Peake, but as a psychiatrist you have demonstrated your skill because you have anticipated my final request, and that is perhaps your Association can communicate with your parent organization to look into the financial aspect and how it affects productivity, and we would welcome your submission, documents on the subject, including such points as you have touched on, as you have pointed out that out of your experience only two cases out of more than 100 of schizophrenics were not curable, and this is a very impressive sort of performance and it does mean that early and comprehensive treatment can mean a gain to the community as a whole and benefit everybody including the patients themselves. Do we then understand that this request will be passed on to your parent organization?

DR. BECK: Yes.

THE CHAIRMAN: Thank you very much, gentlemen, for this presentation. As Dr. Baltzan has said, it is of a very high order and reflects again the benefit that goes to the voluntary organization such as yours which interests itself in these extremely important problems. Thank you very much.

We will now hear from the Prince Edward Island Association for Retarded Children.

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We will now hear from the Prince Edward [illegible]

SUBMISSION OF THE PRINCE EDWARD ISLAND ASSOCIATION FOR RETARDED CHILDREN

---EXHIBIT NO. 35

APPEARANCES: Mr. J. Watson McNaught

Roy M. Smallman

Dr. M.N. Beck

Miss J. Comiskey

MR. McNAUGHT: My Lord, associated with me in this presentation is Dr. Beck and Mr. Roy Smallman, President of the Prince Edward Island Association for Retarded Children, and Miss Comiskey, who is active in this work.

At the outset I must say that we thoroughly approve and endorse a brief that will be submitted at the Toronto meetings by our parent association.

The Prince Edward Island Association for Retarded Children approve and endorse the brief of the Canadian Association for Retarded Children which will be submitted to the Commission at the Toronto meeting.

The matters contained in this brief are largely of a purely provincial nature.

It is submitted that there can be no clear line of demarcation between the fields of education and health in the treatment of the mentally retarded child. There must inevitably be an overlapping. It is desirable, therefore, for the Association to present the following views to the Commission although some of them might be more properly submitted to a Commission on education. I think this is the one

[illegible]MISSION OF THE PRINCE EDWARD ISLAND ASSOCIATION FOR RETARDED CHILDREN

[illegible]

[illegible]

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The Prince Edward Island Association for Retarded Children approve and endorse the brief of [illegible] will be submitted to the Commission on the Toronto [illegible].

The matters contained in this brief are largely of a purely provincial nature.

It is submitted that there can be no clear line of demarcation between the fields of education and health in the treatment of the mentally retarded child. There must inevitably be an overlap.

It is desirable, therefore, for the Association to present the following views to the Commission although some of them might be more properly submitted to a Commission on education. I think this is the one

that caused me the most concern, and that is the differentiation between the educational aspects of the retarded child and the matters that pertain to the medical.

In the past, society has tended to ignore the problem of the mentally retarded. I think it is well recognized that for years the mentally retarded child is shoved off in the background and the problem is ignored. This was wrong. It is only by bringing the problem into the open that beneficial improvements can be realized. In the past decade or so, there have been some newspaper and magazine discussions of this problem. Those discussions have been most helpful; they get the problem into the open, and once it is into the open 90 per cent of our problems are solved. It is submitted that much more could and should be done to acquaint the public with the facts surrounding mental retardation and what can be done to aid the mentally retarded.

It is now generally accepted that much can be done through educational facilities to help the mentally retarded child. But in Prince Edward Island any such educational facilities are practically non-existent. At the present time, there are day schools in Charlottetown and Montague where a dozen or so children receive some training. There should be similar day schools in many other communities throughout the island. There should be similar day schools in many other parts of the island, at least

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a dozen,but that is the problem.

One of the problems met in the establishment and maintenance of such day schools is the lack of trained personnel. That, I think, is a great problem, the efficient and trained teacher. It is submitted, therefore, that there should be some central institution established where persons wishing to be teachers or mentally retarded children could receive adequate training. This the Association regards as fundamental. There should be some central school of people interested in this problem, interested in becoming teachers to receive training. There is a very good school in England where they can be trained, but in Canada it is practically non-existent.

In some of the other provinces and in the United States, the "Sheltered Work Shop" has proved of inestimable value in the training of the mentally retarded. The mentally retarded, of course, can sometimes use their hands, which makes their lives become more full and useful. No such facilities are available in Prince Edward Island. The need exists. Of course, it is beyond the ability of our resources to establish any such workshops,but yet I think there should be one or more to look after these children who should be taught to use their hands and use mechanical skills. It is beyond the financial capacity of the Association to provide such "Sheltered Work Shops". Yet one or more should be provided for the mentally retarded of Prince Edward Island.

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At the present time the government of Prince Edward Island is building an institution which will look after twenty-one mentally retarded children. Fifteen of the twenty-one will be custodial and six will be transitional. This is a step in the right direction; but it is only a step. At least two more such institutions should be established and then only the very minimal requirements will be met.

It is tragic; but nevertheless mentally retarded children are at the present time being housed at Riverside Hospital. They can be maintained at no other place. That is why it is so important that the institutions, referred to in the preceding praragraph, be built without delay.

That to me is a shocking circumstance, that these mentally retarded children are housed at Riverside.

In the past, many mentally retarded adults were housed in the Provincial Infirmary. Recently that institution was converted into a "home for the aged". Such mentally retarded adults were then transferred to Riverside Hospital. Such an institution does not provide a suitable environment for those mentally retarded adults. It is submitted that a 40 bed hospital home of the cottage duplex type be provided for the care of such mentally retarded adults.

At the present time no provision is made for the hospitalization of a mentally retarded person under the provisions of the Hospital Insurance

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At the present time no provision is made for the hospitalization of a mentally retarded person under the provisions of the Hospital Insurance

Commission of Prince Edward Island. It is submitted that where such a mentally retarded person cannot be designated as a dependent, provision should be made for his hospitalization.

It is submitted, and I regard this paragraph as above all fundamental, that the field of research into the causes of mental retardation should be expanded. The research work being done at the present time should be co-ordinated. That is, there is work being done in one university or institution, and in other universities or institutions. The Prince Edward Island Association for Retarded Children realize that until the causes of mental retardation are know, very little can be done to lessen the numbers of mentally retarded children born each year. It is fundamental, therefore, that such research work be greatly increased, and above all be co-ordinated.

Parents faced with the problem of raising a mentally retarded child are in great need of advice and assistance. I mean, it is a problem that very few people can appreciate except those who have had that experience. Proper advice and assistance given at an early stage can prevent unwise, and very often regrettable decisions being made. Yet no such advice or assistance are available. It is submitted that a number of social workers trained in the problem of the mentally retarded be provided to assist and advise the parents of mentally retarded children on the many problems to be met with in the raising of such children.

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Mentally retarded children by the very nature of their physical beings require more diagnostic services than normal children, but due to the difficulties inherent in bringing such children to clinics or private institutions for medical check-ups, the parents tend to neglect taking their children for such examinations. It is submitted that provisions should be made for such examination to be carried out in the home. If that is not done, then the examination may not be done.

Some time ago a very excellent report on mental retardation was prepared by Dr. Malcolm Beck for the government of Prince Edward Island. Such report is attached to this brief as an appendix.

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APPENDIX "B"

REPORT

TO

THE MINISTER OF HEALTH

PROVINCE OF PRINCE EDWARD ISLAND

ON

A SUGGESTED PROGRAM

FOR THE CARE OF

MENTALLY RETARDED CHILDREN

ON PRINCE EDWARD ISLAND

by

M. N. Beck, M. D.

July 1959

DEPARTMENT OF HEALTH

DIVISION OF MENTAL HEALTH

Mental Health Clinic
Charlottetown, P.E.I.

July 20, 1959

The Hon. Dr. M. L. Bonnell,
Minister of Health,
Province of P. E. I.

Re: A Suggested Program for the Care of "Mentally Retarded Children" on Prince Edward Island

Dear Mr. Bonnell:

In May of this year the Government of Prince Edward Island sent me on tour to examine the programs on the management of the "mentally retarded" in several leading centres. I wish to thank you and your Government for exposing me to this valuable progessional experience which, although strenuous, was enjoyable; I trust that the time and money involved were well spent.

The following report cannot help but be highly influenced by my personal opinions, however, I have tried to tone these down wherever possible, and on this tour made a definite point of checking my own views against those of others more experienced and more competent in this field than myself.

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"Mental retardation" presents our society's concern for its less fortunate members with a very

definite challenge. It also presents us, as professionals, with a problem of many facets, some of which have been met with proven techniques, and others for which new techniques will have to be developed.

The program outlined below is based primarily on techniques well proven in other areas; but also contains some methods not as widely established. The highly rural nature of our Province and its small population necessitate some innovations.

OUTLINING THE PROBLEM

1. Definition

Although a precise definition of "mental deficiency" or "retardation" is almost impossible, the following is a somewhat satisfactory one: "Mental retardation is a symption usually permanent, which manifests itself in a given environment by varying degrees of social incompetency due in whole or in part, to intellectual limitation". It is not to be confused with mental illness, which may be likened to "irrationality" while mental deficiency may be likened to "inadequacy".

We now know some 70 different causes of mental retardation; but as yet, the cause is not known for the great majority of cases. As with persons of normal intelligence, each individual called "retarded" is distinctly different from every other retarded individual.

Although retardation has been "stigmatized" as an hereditary condition, modern research has forced us to the conclusion that hereditary factors are important

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Although retardation has been "stigmatized" as an hereditary condition, modern research has forced us to the conclusion that hereditary factors are important

in less than one-third of the cases. Especially in the more severely retarded groups "retardation" exhibits a notorious disrespect for persons, and is found with equal frequency in homes of the rich and the poor, the successful and unsuccessful, the intelligent and the unintelligent.

It is customary to consider "retardation" in three categories, graded as to the severity of the intellectual deficit.

(a) "Educable" - Individuals in this category, although limited in intellectual ability to the extent that they can be diagnosed as retarded, are yet capable of achieving a grade 2 to 5 level of education. With proper education and early training they are capable of becoming useful, independent and productive citizens although necessarily engaged in the less complex types of occupation. These people in terms of I.Q. have an intelligence range of from 50 to 70, and their mental ability in adulthood will not exceed that of an average 10 year old child. In some respects, their state is more frustrating than that of those of lower intelligence as their detection is often missed, and they are subjected to expectations at home and at school, which are beyond their ability to perform.

(b) "Trainable" - These children have an intellectual deficit of such degree as to render them incapable of becoming independent, self-supporting citizens. However, they remain with the ability to perform

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(b) "Trainable" - These children have an intellectual deficit of such degree as to render them incapable of becoming independent, self-supporting citizens. However, they remain with the ability to perform

simple tasks, and can quite definitely contribute to the function of the home unit. As with persons of normal intelligence they are subject to the usual joys, vexations, and other emotional experiences of life. In terms of I.Q. they are usually considered to have an intelligence range of between 25 to 50, and in their adulthood their mental ability will not exceed that of an average 8 year old child.

(c) "Non-Trainable" - These individuals have an intellectual deficit of such severe degree that they usually do not develop the ability to communicate intelligently in speech, and often do not develop the ability to walk. They are thus totally dependent on others for feeding, sustenance, and elementary care.

In terms of I.Q. their intelligence is considered to be below the range of 25 - 30, and as adults their mental age will not exceed that of an average 3 to 4 year old child.

II. Statistical

The generally quoted figure of 3% of the population falling into the retarded category is undoubtedly a conservative one, and I suspect especially conservative for Prince Edward Island. Using this as our base then, on Prince Edward Island we have:

3,000 - retarded persons.

1,150 - retarded children 16 and under

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Of these 1,150 children:

- 875 (75%) are "Educable"

These figures are substantiated in Summerside where a result of a comprehensive survey we now know 20 children in the educable category among the 600 pupils in the elementary schools.

- 230 (20%) are "Trainable"

We now know about 100 of these through contact with the clinic and/or the Association of Retarded Children.

- 55 (5%) are non-educable and "Non-Trainable"

III. Historical

Society has long ignored this problem to its own detriment. The earliest institutions in North America for the care of the retarded were founded in New York State and the Province of Ontario in the 1840's. Progress in this type of care has been erratic. Special educational opportunities for these individuals have also been irregularly provided, and in only a few areas go back over 40 years.

Prince Edward Island has good reason to be ashamed of its own performance in regard to its care of this large portion of its population, as we have taken essentially no steps to counteract the mal-effects of this condition. We have not yet organized any special teaching facilities for the "retarded", nor have we provided anything in the way of adequate institutional care for them; although some are cared for in the

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Provincial Infirmary.

This whole problem has recently been thrust into public attention by the meritorious, the importunate, work of the "Associations for Retarded Children"? These groups, as you know, have been active on Prince Edward Island as elsewhere. Usually they have been started by the parents of retarded children, but they are now receiving widespread support from other public spirited citizens. As a result of the efforts of the A.R.C.'s the last decade has seen widespread activity in this field - hundreds of classes for retarded children have been started; legislation regarding mental deficiency has been revised in all but 6 of the 48 states since 1950; widespread services for the "retarded" have been set up and society has awakened to its long negligence regarding this problem.

As important as these are, perhaps the most valuable contribution of these groups has been the change which they have brought about in public attitudes toward mental retardation. If their good work continues (and almost certainly it will) it is to be hoped that this stigma will ultimately be resolved.

IV. Discrepancy Between Potential and Function

While we have to accept the fact that with our present knowledge there is little or no possibility of increasing the basic potential of the retarded individual, this is by no means true of their functional level. The striking thing about this whole problem is that consistently "retarded" people are functioning at a

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level grossly below their capacity, limited though this is.

Although these persons do have a great potential for happiness and for productivity on the more simple levels of effort in our society, at the present time not only is this potential unused, but in too many instances they now constitute only an emotional and material drain on the productive members of our society. To state this bluntly, where they are now parasites on society they could and should be contributors.

This is particularly true at the educable level; but also applies to the trainable level, where, although they will of necessity always be dependent, with proper early training this dependent position can be altered from that of a draining dependency to a useful dependency; they can, and should, become assets to the home in their dependent role.

V. Stress on Families

(a) Physical - In regard to the non-trainable group, or in those rare cases where there are two or more retarded persons in a single household, the family is presented with a major problem of straight physical effort. The "Non-trainable retardates" can often be cared for rather satisfactorily at home for the first 8 to 10 years, but after this their increasing size makes home care almost impossible.

(b) Emotional - The emotional strain placed on these homes by the presence of a retarded child is a

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quite complex problem. Those of us who are fortunate enough to have children of normal intelligence, should realize that, because of their very normality we have within us an unconscious measuring rod which fits our particular child. This is not at all the case with the parents of a "retarded" child, and requires in those parents the kind of adjustment that most of us cannot make without help. Here, wise counselling is often necessary to prevent disturbing emotional patterns being set up in the household.

These parents are still people, and unfortunately, are sensitive to the usual stigma which society places on those who are "retarded". Possibly because of this, or for other reasons, they frequently develop a sense of guilt as parents of a "retarded" child. Many parents are able to deal rather nicely with such stresses; however, some will require individual help with their emotional problems.

(c) Social Stress - These parents must re-align their life to an extreme degree. They are often unable to get someone else to care for their children, and therefore are continually bound to the home. Should they wish to go out for an evening they are unable to use the services of baby sitters. Vacations away from home are often impossible for them. In some instances, they are unable to invite others into their home, and in many more instances are reluctant to do so because of the presence of their "retarded" child. Social dislocation such as this demands major readjustments.

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(d) Stress on Siblings - "Retarded" children in the home often place a great deal of stress on their brothers and sisters of normal intelligence. The retarded child requires a disproportionate amount of the parent's time, and the normal sibling may react to this with a sense of rejection. In some cases the normal child is often unduly sensitive to the presence of the "retarded" sibling and on this account excludes his social acitivities from his home.

VI. The Retarded Child from the Broken Home.

There are some "retarded" children in homes which are broken, or in homes too inadequate to deal with the normal problems of family life. Such conditions pose an unsurmountable problem to the retarded child, and present society at large with a situation demanding alleviation.

VII. Social Mal-Adjustment

Largely as a result of our maladroit handling of retarded children, disproportionately large numbers of retardates are foundin such areas of social maladjustment as juvenile and adult delinquency, social assistance and child welfare cases. Some families present problems in practically all areas of life, school, court, marital and social; and these Multiple Problem Families demand a grossly disproportionate amount of our social agencies' time. It is estimated that of such families one-third are homes in which one or both parents are retarded. This is in stark

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contrast to the 3% figure of retarded people in the total population.

With proper handling of the "retarded" person during his childhood, situations like this should be avoided in later life. Indeed, in Denmark, where an adequate program for dealing with the problem of retardation has been in force for a longer time than in this country, juvenile delinquency has been shown to have no higher incidence among the "retarded" than among the normal population.

VIII. What Happens on the Parent's Death

Practically all parents of retarded children are concerned as to what will happen to their retarded child on their death. This problem is particularly acute with the cultural pattern of Prince Edward Island, in which so many members of the retarded child's family move to other provinces, and there set up homes unsuited to the care of their retarded sibling. This is a very realistic problem and one which must be met with legal provisions, which will guarantee to these parents the concern of society for their retarded child in such unfortunate circumstances.

Summary

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Island, in which so many members of the retarded child's family move to other provinces, and there set up homes unsuited to the care of their retarded sibling. This is a very realistic problem and one which must be met with legal provisions, which will guarantee to these parents the concern of society for their retarded child in such unfortunate circumstances.

Here then, beyond any point of question, we are faced with a tremendous problem, one of many facets, one in which many citizens are not nearly as productive or (perhaps more important) not as happy as they

should be and further, one which places many of the productive members of our society under inordinate stress. This is a problem demanding great concern. It is further a problem which can be helped to a very considerable extent by the provision of an adequate program. Though such a program might seem extensive and expensive, especially in regard to its staffing, it has been abundantly demonstrated elsewhere that where these services are provided society as a whole benefits, as well as the retarded individuals themselves and the families who are faced with the immediate problem.

BASIC PRINCIPLES FOR A COMPREHENSIVE PROGRAM

1. Concern for the Individual

Our society has been blessed abundantly by two great influences. The first is that of the Christian Religion where under the favour of a loving God, we as individuals and as a society have become spiritually free, and thus enabled to direct our concern, and effort toward the welfare of our fellow man. Secondly, (and growing out of this Christian influence) we have been favoured by the British democratic tradition, under which we have become alerted to the inalienable rights of every member of our society to equal opportunity for personal development, stability, happiness, and freedom. Under these influences, our citizens have repeatedly shown themselves responsive to areas of need when such need is clearly demonstrated.

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One might adduce here our provisions for public health, universal education, child welfare laws, old age pensions, and recently hospital insurance. The large number of regarded individuals on P.E.I. again presents us with a clear focus of great need, and under these two great influences we can expect our people to support a comprehensive program directed to this problem. A program which attempts to give to each individual an opportunity to develop the best of which he is capable, first and foremost for his own welfare, and secondly, to serve the common cause.

II. Paramount Importance of the Home.

It has been repeatedly and convincingly demonstrated in both psychiatric and child care service that any individual whether or normal intelligence or retarded, will develop a more adequate personality pattern under the influence of his own home than under the influence of even our best institutions. Although there remains the odd exception to this rule, this principle has been established beyond any reasonable shadow of doubt.

It therefore becomes mandatory that any program for the satisfactory handling of this problem must be done with this principle being as carefully adhered to as possible.

III. Secondary Importance of Substitute Homes

Again, especially deriving from the experience of Children's Aid Societies and other child welfare agencies, the professionals concerned have been able repeatedly to demonstrate that where possible, and where

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Again, especially deriving from the experience of Children's Aid Societies and other child welfare agencies, the professionals concerned have been able repeatedly to demonstrate that where possible, and where

good foster homes can be found, children develop more satisfactorily therein than in our most adequate institutions. Again, this principle in any well rounded program will be ignored only to the detriment of the effectiveness of that program.

IV. Home Oriented Programming.

Realizing that the home remains the buttress of our society, and also that where a satisfactory home is not in existence that substitute homes should be provided, it becomes essential that any development in the area of care for retarded children should centre on the provision of service facilities to the home and in the community rather than in the provision of large and expensive institutions, which cannot measure up to the results obtained by home-based programs.

From the experience gained through the modern techniques of social work, psychology, and psychiatry, we now know that homes in crisis can often be stabilized by the provision of adequately trained and properly oriented counselling and counsellors; and if staff is adequate, that crises can often be prevented. Thus we can be reasonably sure of the practicality of this type of program although it does demand a heavy staff.

To quote the report of the California Joint Interim Committee on Education and Rehabilitation of Handicapped Children and Adults, "Families of mentally retarded children should have competent counselling and guidance to aid them in the acceptance and fulfillment of their responsibilities to their retarded children,

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and other members of their family, when needed to avoid the development of unhealthy attitudes within the home." Parents have an obligation to provide for their children, and when possible and desirable should not be deprived of the privileges of having their children with them."

It is the impression of every person in this field that not only is it much better for the welfare of the handicapped individual to concentrate efforts on such staff; but also that it is less expensive to the state. Though the latter is not easy to prove, the New Jersey commission "To Study the Problems and Needs of Mentally Deficient Persons", has gone on record that, "Mentally retarded children can be trained within their homes or community settings for one-third the cost of state residential care", and "The cost of public school classes is less than one-half the cost of such services within institutions".

V. Changing Trends in Institutional Care.

In all areas I have visited, the trend is very definitely away from the Institutional Care of the "educable child". Generally the only "educable" children admitted to Institutions now, are those who, in addition to their intellectual defect, present other problems such as emotional or social disturbances. Under the limited terms of admission practiced in other areas the problem of setting up a "Training School" type of institution in Prince Edward Island is impractical if, for no other reason, than the small number of

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persons to be placed in such an Institution.

In New Jersey where aggressive legislation regarding community services for retarded children was introduced in 1954, the Institutions which had previously been set up for the care of the "educable" child are experiencing a very definite decrease in this type of admission, and are now projecting plans for a radical change in their Institutional Programs within the next five years. This situation is also dramatically illustrated by the Ontario Institutions where the percentage of "educable" persons in their institutions has decreased from 45% in 1939 to 20% in 1959.

These seem to be absolute demonstrations of the fact that, given adequate community services, these children can be satisfactorily and effectively cared for in their homes.

VI. Orientation to Prevention.

Although the problem of our adult "retarded" population is one of major magnitude it would seem wise to concentrate our efforts toward the provision of proper care and services for "retarded children."

Many of the problems associated with "retardation" are entirely preventible, and given adequate opportunities during their formative years, along with continuing supervision, the great majority of our present problems with the large "retarded" portion of our population would be avoided.

VII. Development of Maximum Potential.

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VII. Development of Maximum Potential.

It is undoubtedly the right of every one of our citizens to experience the development of his or her potential to its full extent. This is true regardless of the degree of potential, and with "regarded" children (who are "more like persons of normal mental ability than they are different from them") the sense of achievement from a task or an opportunity well done presents the same satisfaction and rewards as that produced by a similar experience in his more talented brother or friend.

(a) "Educable" children deserve the right of educational facilities designed to meet and develop their decreased ability to assimilate knowledge.

(b) "Trainable" children deserve the right to the development of their potential by training in social development, habit training and simple work functions.

With these the educable child can develop to a productive independent adult, and the trainable child to a productive adult in a setting of dependency.

VIII. <u>The Relative Unimportance of Intelligence</u>

Beyond a critical minimum, intelligence has in a great many of the areas of life, little significance and is often a most unreliable indicator of vocational adjustment and achievement. Of much more significance as indicators of success are our personal motivation, emotional maturity, social competence, independence, and desirable work habits. In these important spheres

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the great majority of our mentally retarded, given consistent and intelligent opportunities and guidance, are entirely capable of excellent development.

IX. Role of the Institution.

It will be seen in this report that Institutional Facilities play only a moderately important role in the total program for the care of the "Retarded".

Primary stress should indeed be placed on Educational and Home Strengthening Services, with the Institution dealing only with cases that cannot be adequately handled by these services and other Community resources.

However, one other key role remains for the institution - it should serve as a centre and hub for the Community oriented phase of the program, and should provide a location for central office space and records; a location for practical experience and On-Service Training of the community workers; and finally a location in which the personnel of the institution would be stimulated by the personnel of the educational and home strengthening programs, who in turn would be stimulated by the personnel of the institutions.

The institution should be a centre of information, communication, and vitalization, for all workers engaged in this comprehensive program.

X. The Necessity of Continuous Community Association

Repeatedly in the history of all institutions

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there has occurred a stultifying influence in the loss of community interest in the institution. This is now abundantly true of our Provincial Infirmary; it remains partly true of Riverside Hospital, and in the past has had an extremely oppressive influence on the patients there.

It is imperative that the program of an institution be set up to counteract this tendency. The administrative personnel must openly recognize this possibility and take aggressive action to counteract it. The community will retain its interest provided its support is asked for and encouraged.

In the case of an institution for retarded children the presence here of active functional units of the Prince Edward Island Association for Retarded Children should do much to forestall this tendency. However, in the type of institution described below, such a tendency would be particularly strong. To meet this danger some specific measures to deal with it are suggested.

OUTLINE OF A COMPREHENSIVE PROGRAM

1. Adequate Diagnostic Services

2. Special Educational Facilities

   (a) Individual Advancement Classes
   (b) Vocational Classes
   (c) Day Training Schools
   (d) Home Teachers

3. Home Strengthening Services

4. Institutional Services

   (a) Residential Care
   (b) Day Care

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2. Special Educational Facilities

   (a) Individual Advancement Classes
   (b) Vocational Classes
   (c) Day Training Schools
   (d) Home Teachers

3. Home Strengthening Services

4. Institutional Services

   (a) [illegible]
   (b) Day Care

5. Recreational and Social Facilities

6. Professional Training and Retention of Staff

7. Research

8. Legislation

ADMINISTRATION

The program and institution outlined herein would be most adequately handled by a commission composed of representatives of government, and citizens highly interested in this field.

Failing this, the following chart represents possible lines of administration and communication within our present system.

I. DIAGNOSTIC SERVICES

Adequate diagnostic services present the basis for any well designed program. This will require the active involvement of the Child Guidance Team at the Mental Health Clinic (psychiatrist, psychologist, and social worker), as well as the active participation of the pediatricians of Charlottetown, and close co-operation with the general practitioners of the province. The Liaison Teachers program, which is in the process of development, will play a key role in diagnoses and case finding.

In P. E. I. we are in a rather fortunate position in regard to our diagnostic services.

II. EDUCATIONAL SERVICES

(a) Individual Advancement Classes

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II. EDUCATIONAL SERVICES

(a) Individual Advancement Classes

In the ordinary graded class room, the "educable" child is subjected to excruciating and exquisite frustration.

This stress on the child can be largely resolved, and his acquisition of knowledge greatly increased, by placing him in an Individual Advancement Class. These are classes set up within the existing school system; kept small enough (10 - 15 pupils) to allow each student increased individual attention from the teacher. Here the child is allowed to move ahead at his own rate, and is thus not subject to the frustration imposed on him by the usual graded course, in which he is expected to maintain position in a grossly unfair competition with his peers of greater natural endowment.

The number of such classes needed are startling (that is, startling unless one remembers the magnitude of the problem) and can be projected as follows: in the Charlottetown area working from theoretical figures we would need 6 to 8 such classes. In the Summerside area working from already established figures we need 2 to 4 such classes. In addition, in centres such as Montague, Kensington and comparable towns we would need 1 to 2 such classes in each community.

To derive maximum benefit it is necessary that children be started in such classes by age 7, or at the latest, 8. This requires extensive diagnostic facilities. Screening processes of all grades 1 are almost imperative, and satisfactory services of this type can be obtained only with a greatly increased development of our Liaison Teacher program. (These

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personnel, as you know, are experienced teachers who have been given a one year course in mental health principles and are now functioning in the Division of Mental Health as liaison personnel between the schools and the Mental Health Clinic. They receive supervision by the clinic staff, and On-Service Training by our Psychologist). School Psychologists in the Summerside and Charlottetown areas would contribute immeasurably to the success of such a program.

"Educable" children should remain in a special class setting up to the age of at least 16, indeed, in countries with a highly developed program such as Sweden, it is now becoming common practice to keep them in such classes until the age of 20 to 21.

It should be noted that the removal of the slow learners from the ordinary classroom is of great help in speeding the progress of the students of normal intelligence.

Although the above-noted frustration is experienced by the "retarded" sutdent in the graded classroom, this is not as marked with the "retarded" student who receives his education in a one room school. Other things being equal (which is often not the case with our present high concentration of unqualified teachers in the one room schools) the retarded educable child in the one room school can move along at his own pace without unduly disturbing the academic routine of the school, and there can take advantage of the learning opportunities presented when younger students are being instructed.

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This introduces the possibility of two appropriate methods of handling the "educable retarded" child in the rural areas.

1. Improvement of the Relatively Satisfactory One Room School Setting by:

(a) Increased individuation in teaching the retarded child. This is necessary, and but gives tacit recognition to what now often happens in actual practice. An "educable" child in the one room school should, where possible, and necessary, constitute a grade by himself.

(b) Improvement in the training of teachers in the education of "retarded" children at the normal school level.

(c) Increased orientation of teachers to the needs of retarded children through counselling by Social Workers, Liaison Teachers, and Home Teachers.

(d) Home Teaching Services.

2. Transportation of Retarded Children to Specialized Classes in the larger centres. This would best be done by the parents or by voluntary groups.

(b) Vocational Classes - Vocational classes for the "educable retarded" are need to smooth the transition from the Individual Advancement Classes to the work situation. They should be set up for the service of children from the ages of 14 - 16 to 21. Such a program would present rather formidable problems on Prince

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Edward Island in areas other than Charlottetown. There remains the uninvestigated possibility of working out some plan with the cooperation of the Vocational School; however, this is yet very nebulous, and requires further development.

It is also possible in the Charlottetown area to utilize the domestic needs of the proposed institution for retarded children, and of our other institutions, in a program of prevocational training for the "retarded".

In other provinces, which are more highly industrialized, the establishment of "Sheltered Workshops" has become a very dominant part of the community program for the retarded; this type of program is usually based on piece work in industrial occupations. The possibility of setting up such a program on P.E.I. based on "service occupations" remains a possibility, but I would like to see some other rural area try it first. The essential link provided by sheltered workships in the total program for the retarded elsewhere can perhaps be substituted for on P.E.I. by the utilization of,

1. Liaison with the vocational school.
2. Vocational placement in domestic or farm employment with supervision by a trained staff.

The establishment of "Individual Advancement " and "Vocational" classes will require the Introduction of the following:

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the Department of Education. In most areas such a person is placed on the school boards of the larger cities; however, on Prince Edward Island he would be more suitably placed in the Department.

2. Additional Provincial Grant - With an Individual Advancement Class containing a maximum of 15 students, the cost for such a class is approximately double that of a "normal stream" class. Also, in order to attract personnel into this difficult type of teaching, it is necessary to offer a premium of $300 to $500 over that received by teachers of the "normal stream" classes. It has been found everywhere that local school districts are unwilling to assume all this financial burden, and the program of Individual Advancement Classes has prospered only when substantial additional monies for such a purpose are granted to the school districts by the provincial or state bodies. In most areas the state or provincial governments double the allotment which they give for a class of students of normal intelligence.

3. Expanded Liaison Teacher Services.

4. Permissive or Mandatory Legislation (see below)

(c) Day Training Classes

These are classes of 5 to 8 pupils set up in the community for the "trainable " retarded. In such a class emphasis is swung away from academic achievement and is placed on social training, habit training, training in manual dexterity, and training in the fundamental rules, dangers, and amenities of life. As a rule,

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children attend such classes for only half the day. We now have two such classes operating in Charlottetown supported by the Canadian Legion and the Provincial Government, with the Charlottetown School Board providing classroom space at West Kent School.

On Prince Edward Island the only area with sufficient population demand for a permanent Day Training School is Charlottetown, and district and our present classes satisfactorily meet this need in this area. The Charlottetown area Day Training class should be placed in the proposed institution to counteract isolation of the institution from the community.

In other areas one would visualize a somewhat mobile class, possibly involving three districts with the teacher rotating from one district to the next. Such possible combinations would be the Summerside, O'Leary, and Alberton areas; and the Montague, Murray River - Murray Harbour, and Georgetown areas.

Such Day Training Schools would necessarily derive their major support from the Provincial Treasury. In other areas, where there are larger concentrations of population, this level class has progressively been included in the school system and, in many states, "mandatory legislation" has been passed obliging local School Boards to set up such classes where the demand exists. However, this system could not be used on Prince Edward Island where we have only one area with sufficient demand in itself; and it seems apparent that where three communities are involved the only method

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In other areas one would visualize a somewhat mobile class, possibly involving three districts with the teacher travelling from one district to the next. Such possible combinations would be the Summerside, O'Leary, and Alberton areas; and the Montague, Murray River - Morris Harbour, and Georgetown areas.

Such Day Training schools would necessarily

In other areas, where there are larger concentrations of population, this level class has progressively been included in the school system and, in many states, "mandatory legislation" has been passed obliging local School Boards to set up such classes where the demand exists. However, this system could not be used on Prince Edward Island where we have only one area with sufficient demand in itself; and it seems apparent that where three communities are involved the only method

of financing such a program would be from central sources.

Such a program should continue to receive partial support from the community. This would apply especially to the provision for transportation of the children, and/or teacher. If present practice can be used as a guide, this would be forthcoming from Associations for Retarded Children and other service organizations.

(d) Home Teachers

In England, in New Zealand and in many of the states of the U.S.A., mobile teaching services have been provided for "retarded" children of rural areas. In Sweden they have taken it one step further and established mobile classrooms in Volkswagen buses.

Such teachers would serve real needs in:

1. Academic Instruction of retarded children.
2. The orientation of the teacher of the local one room school.
3. Support and counselling for the home. These services would be improved by the use of correspondence courses, which have been well worked out in other centres.

In the visualization of a comprehensive program for the retarded, we should start on an experimental basis, with one such teacher who would serve a limited, exclusively rural area; and expand this type of service as success indicates, and available staff permits.

III. HOME STRENGTHENING SERVICES

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In the establishment of a comprehensive program for the retarded, we should start on an experimental basis, with one such teacher who would serve a limited, exclusively rural area; and expand this type of service as success indicates, and available staff permits.

Repeatedly, in talking with personnel active in mental retardation, and in reading the literature concerning this problem one meets two constant refrains.

1. We need more counselling and orientation for families.
2. We need more supervision, and continuing supervision, of the retarded child and adult in the community.

Such services can be provided only by the provision of highly trained Social Work personnel. These people would have to be mobile, as a great deal of their effectiveness would be connected with service to retarded individuals in rural areas.

They would perform the following functions:

(a) Orientation of the family to the problem of mental retardation.

(b) Assistance in home training.

(c) Assistance in home teaching.

(d) Assistance to parents in planning the most appropriate program for the child, and continuing counselling and supervision to see that this program is carried out.

(e) Continuing supervision in the community of the retarded individual beyond his discharge from special education classes and/or from the institution.

(f) Establishment of group counselling and/or group therapy sessions for parents of retarded children.

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(e) Continuing supervision in the community of the retarded individual beyond his discharge from mental education classes and/or from the institution.

(f) Establishment of group counselling and/or group therapy sessions for parents of retarded

(g) Job placement of retarded individuals.

(h) Counselling of employers of retarded individuals.

(i) Foster home securement and placement.

(j) The use of foster homes as "half-way houses" between the institution and the community as transitional centres to independent community placement.

This program should achieve the two objectives:

1. The prevention of home breakdown, through the often preventable stress on the family presented by the retarded child; with a related decrease in the rate of institutionalization.

2. Supervision of the retarded individual in his assimilation into the community; with a related prevention of community problems and an improved handling of community problems should they arise.

Adequate services in this line would require, as a minimum, two social workers fully trained and competent in social work techniques. We now have in training, Miss Cummiskey who will be an excellent person to initiate such a program. She should have the help of another social worker to continue and/or extend this program. In addition to this and working under them we could definitely consider the On-Service Training of one or two untrained workers.

It is generally felt that specialized workers in the field of retardation are necessary to adequately put across this type of program. The utilization of other personnel such as Liaison Teachers and Public Health Nurses, is a possibility, but the use of such

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personnel would be effective only if the key social workers mentioned above are behind it.

This type of program will necessarily be closely integrated with the work of the Division of Child Welfare. This is presently possible, even with the gross shortage of staff in this Division. If this shortage of personnel in the Child Welfare staff is relieved (and it must be sooner or later) gratifying improvement of both Child Welfare Services and services to the retarded can be anticipated from close cooperation between the divisions.

IV. INSTITUTION (see page 33)

V. RECREATIONAL AND SOCIAL PROGRAMS IN THE COMMUNITY

Most areas I visited are establishing such functions for their retarded, and this is necessary and wise. Such services are provided through summer camps, occupational therapy groups, social activities, religious programs, etc.

These are best handled by Community Groups and Organizations, such as the A. R. C.'s and should be left in their hands.

VI. PROFESSIONAL TRAINING AND RETENTION OF STAFF

This is the key problem of any program whether the program be oriented to institutional or community type services. Key staff who are highly trained and highly intuitive to human needs are indispensable. This requires adequate salaries for recruitment, and, what is even more important, adequate salaries for the

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of study Prince Edward Island presents unusual opportunities for research.

It has been well proven that the cost of research is more than returned by the vitalizing effect it has on any community or institutional programs.

It therefore seems sensible that for every dollar expended by the Provincial Government in this field an additional 20 or 3 cents be set aside for research. Necessarily, this will take some time to build up a usable fund. However, one could visualize that in a few years there would be sufficient monies to attract research personnel. With such personnel here, it would be quite possible to derive further research funds from such sources as the Federal Government Research Grants and various private foundations.

VIII. LEGISLATION

Looking back on my tour it appears that I have paid insufficient attention to the legislation necessary to make such a program as this feasible. I am now attempting to overcome this defect by securing copies of legislation from various sources, however, this will not be at hand until after composition of this brief. Consultation with others more competent in the legislative field should be secured.

As a tentative breakdown of the necessary legislation, we should concern ourselves with the

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retention of such staff.

To maintain the vitality of a program such as this it will be necessary to develop a well organized, continuing Training Program. At the present time one would see this being carried out at the following levels : (a) Federal Mental Health Grants can be used for training of Social Work Personnel. (b) Institutions such as the Southbury Training School in Connecticut would, I am sure, be glad to cooperate in training key staff personnel for us, (c) The facilities of the institutions and key staff personnel can be utilized for training of persons at the undergraduate level. (d) Teachers for Individual Advancement Classes should be selected from experienced teachers, and adequate summer school courses are available for their further training. (e) Teachers for the Day Training Class program can be trained in our present Day Training Class, this being supplemented by summer courses.

VII. RESEARCH

This may sound fanciful, however, its innate logic cannot escape us. The ultimate solution to the problem of mental retardation will comeonly from research. This is especially true in reference to the biological processes involved in the development of the human embryo. However, much remains to be known regarding the psychological, educational, social, and cultural aspects of this condition; and in these areas

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following areas:

(a) Registration - Registration of the mentally retarded should be obtained from physicians, clinics, parents, etc. This would provide an invaluable survey of this immense problem.

(b) Guardianship - Some legislation regarding Provincial guardianship of the retarded individual is necessary to protect the child and/or adult individual in case of calamity to the family. And, also, to give the staff of the organizations concerned with retardation, the necessary responsibility for working out an appropriate program for the retarded individual.

(c) Provision for a boarding out program, similar to that now enacted for our mentally ill population.

(d) Educational - Either of the "permissive" or "mandatory" type, that is, legislation either enabling or requiring the local school boards to provide adequate services for the retarded population where a need for such services exists.

IV. INSTITUTIONAL FACILITIES (referred from Page 30)

Despite the increasing emphasis on community services, an institution remains necessary for a certain small proportion of our retarded population. Institutional services will have to be provided on the following levels:

1. Residential care of the severely retarded.

Registration - Registration of the mentally retarded should be obtained from physicians, clinics, parents, etc. This would provide an invaluable survey of this immense problem.

(b) Guardianship - Some legislation regarding involuntary guardianship of the retarded individual is necessary to protect the child and/or adult individual in case of calamity to the family. And, also, to give the staff of the organizations concerned with rehabilitation, the necessary responsibility for working out an appropriate program for the retarded individual.

(c) Provision for a boarding out program, similar to that now enacted for our mentally ill.

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Despite the increasing emphasis on community services, an institution remains necessary for a certain small proportion of our retarded population. Institutional services will have to be provided on the following levels:

1. Residential care of the severely retarded.

2. Residential care of transitional cases.

3. Day care program.

CONSIDERATIONS REGARDING INSTITUTIONAL CARE

1. Residential care should be provided for only those who cannot be properly cared for in their own home or in a suitable foster home.

2. The institution must be oriented to the development of the individual to the maximum use of his potential. This will involve not only the establishment of a satisfactory emotional climate in the institution, but also extensive use of occupational therapy and industrial therapy. These might be provided in association with the programs now being established at the Riverside Hospital, and also by the use of Falconwood Farm.

3. The institution should be designed to approximate a normal home situation as closely as possible. This will involve consideration in planning the physical plant of the institution, and especially in the planning, selection and training of staff.

4. Active recognition and prevention of isolation of the institution from the community is necessary and should proceed along lines outlined elsewhere.

5. The care of the low grade, non-trainable, retarded individual represents a humanitarian

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The care of the low grade, non-trainable, retarded individual represents a humanitarian

problem that must remain high on the list of public responsibilities.

6. The institution should serve as a hub for this whole program.

ADMISSION POLICY

Admission Board

An admission board should be set up consisting of personnel from the psychiatric, psychological, social work and pediatric fields; with representation not only from the Department of Health but also representatives from the Division of Child Welfare and/or other Social Agencies.

This board alone should be responsible for admission and discharge from the institution.

Criteria for Admission to Residential Care

1. The Severely Retarded

Those retarded of low trainable or non-trainable levels whose care demands nursing facilities beyond that of the home.

2. Transitional Cases

(a) Those "retarded" who do not have a home or who are from an unsuitable home, and require transitional care leading to foster home placement.

(b) Those "retarded" who place an inordinate emotional strain on the home either towards parents or siblings, and who for this cause, require temporary removal from the home, or

[illegible] responsibilities.

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transitional care leading toward foster home placement.

(c) Those "retarded" who require temporary placement in the institution for emotional rehabilitation and/or social readjustment - e.g. delinquent retardates.

(d) Those "retarded" who require temporary placement to afford holidays for the parents, or to relieve the home in case of an emergency brought on by sickness or other misfortune.

It is recommended that at least one-third of the bed capacity of the now proposed institution be reserved for cases of "transitional" nature. This will do much to (1) Keep the institution oriented toward achievement, and (a) Break down the potential isolation of the institution from the community.

Those "educable" children coming under this group should be serviced educationally by the special classes in the Charlottetown school system. Such a situation will require negotiations with the Charlottetown School Board.

DAY CARE PROGRAM

Many "retarded" children and adults, can be maintained at home if they are exposed to a program during the day which is oriented toward their level in occupation and/or recreation. It has been extensively shown that such a program of day care, with the child or adult staying at home through the

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night, provides an excellent method of handling even the severely retarded.

As well as providing an excellent service to the "retarded", the provision of this type of program has other advantages,

(a) By thus serving the one-fifth of the Island's population in the Charlottetown area the expense of the total program would be considerably reduced, as there would be less demand for institutional beds. (b) This type of program will do much to counteract the tendency toward isolation of the institution from the community.

In the setting up of such a program service organizations should be relied upon to provide facilities for transportation of the individuals to the institution.

PHYSICAL PLANT

Operating on the frame of reference of the proposed 20 bed institution postulated to me before my tour, the following points should be made:

1. Already the demand, even on the extremely limited admission policy outlined above, exceeds 20 beds.

2. The idea of an initial 20 bed unit should still be retained as this is an excellent size for one unit.

3. The "Cottage Plan" of units based on a home-like building with a bed capacity of 20 is undoubtedly the superior type of physical plant. This

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appears to have little economic disadvantage, and in getting away from the large dormitory type of building the humane aspects of the institution are greatly enhanced. Such a well designed physical plant reflects immediately in the increased personal welfare of those for whom the building is provided. The increased administrative problems posed by such a plant are more than compensated for by the benefits given the children.

4. For ease of administration and for provision of auxiliary services such as laundry, the institution could be placed close to Riverside Hospital.

5. The dining room in each individual cottage is an almost indispensable asset in the training and habilitation of the retarded. Centralized dining room facilities should, therefore, be avoided. However, it would appear from my contact with cottage-type institutions at Southbury, Connecticut and Vineland, New Jersey, that the individual kitchen placed in each cottage provides insufficient training opportunity to merit its inconvenience. These institutions are working toward a central kitchen despite a very definite bias in years past to the individual cottage kitchen. This being so, it would seem wise that prepared food be provided from the already adequate kitchen facilities at Riverside, at least for this initial unit.

6. It is self-evident that the cottage should be a one-floor type. This gives the cottage itself

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6. It is self-evident that the cottage should be a one-floor type. This gives the cottage itself

greater flexibility, enabling the staff to care for any type of mentally retarded individuals therein, whether they are ambulatory, on wheel chairs, or bed-fast. This type of flexibility is particularly necessary in our first unit as it is difficult to foresee just why type of patients we would wish to have there in some 5 to 10 years' time.

The second advantage of the one floor plan is that it provides much in the way of safety for the patients. This is especially true in case of fire, but is also pertinent when one considers that a quite considerable portion of the persons cared for there will be subject to epileptic seizures.

Although the one floor plan is somewhat more expensive than a two storey building, when the additional capital expenditure is spread over the next 50 years, the additional amount becomes quite insignificant in relation to the advantages gained.

7. The design of our initial unit which will necessarily house a wide range of types of persons with retardation, of many ages and both sexes, will pose a very neat problem in architectural arrangement. This will also call for a quite complex staffing arrangement. However, these will not be insurmountable.

8. Professional staff must be included in planning architectural design for the building.

9. There should be a master plan for the whole plot envisioning a minimum of three cottages and a maximum of five. This master plan should include appropriate landscaping, driveways, walks, etc.

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10. Play room space, indoor and outdoor, must be provided. It is felt that sufficient play room space for rainy days should be provided in the basement. In the upstairs dayrooms, and in the basement playroom, dividers for partial separation of groups, should be included.

11. Miscellaneous, the plan should provide definite separation of dormitory and dayroom space. There should be outdoor garden space. Room should be provided for sewing machines, washing machines, and dryers for emergency use, and also to provide a "home-like touch". There should be large bathrooms with at least one water closet for five patients. Tile walls and terazzo floors in the dormitory offer the best solution for a practical yet attractive room.

12. Design of the cottage will necessarily include space for Day Training School facilities, and for Day Care facilities.

13. Office space for the personnel of community oriented services should be included.

STAFF

In the initial proposed unit the necessary staff will be quite heavy. This is dictated by two factors, (1) The wide range of problems that will be housed therein, and (2) Necessary provision of Administrative staff.

I would visualize as key staff who should be started on training immediately:

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I would visualize as key staff who should be started on training immediately:

1. A Social Worker - Miss Jacqueline Commuskey, B.A. has already been started on training for this.

2. A Registered Nurse with personal characteristics suited to this field, who (if she can be found) should spend some 6-8 months in Southbury Training School. Such a person will be necessary to supervise the physical care of the patients.

The administrator of the institution could come from either of these two levels depending on who would seem best suited. Certainly, such an institution, however small, must have a head to handle the families of patients, public relations for the institution, and other problems as they arise.

Other staff will be necessary to put the unit into operation.

1. Cottage Parents - Two sets of husband and wife teams, one for the day and one for the swing shift. These should be warm, loving people, they need not be professional, but they must have a great capacity for human warmth and understanding of the patients. It is, therefore, essential that the final decision on personnel employed for these positions rest at the professional level.

2. Psychiatric Attendants - Male or female, one to cover the night shift and one for the day care of the infirm.

3. One Supervisor of the Day Care Program.

4. One Day Training Class teacher.

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ON-SERVICE TRAINING

This will be provided initially by the child guidance team, the specialist Social Worker, and the specialist R.N. This will need to be quite extensive, and will necessarily come under the supervision of persons who are well oriented and well trained in "Individual Differences."

PROFESSIONAL STAFF

Consultants to the Institutions:

1. A Pediatrician.
2. The Child Guidance Clinic Team.
3. Speech Therapist.

Home Strengthening Services

1. Key staff Social Worker mentioned above.
2. One additional trained Social Worker.

As already mentioned, the necessity of using untrained social workers serving under these two trained workers will need to be considered; as should also the feasibility of utilizing "Home Teachers" in this type of role.

Order of Development of Program

I am not unaware of your request for my outlining a possible sequence in which this program might be developed. I have struggled a bit with this, but would prefer to postpone placing it on paper until such time as the thoughts herein are more fully developed; and until I have some idea of the reactions to these

This will be provided initially by the child guidance team, the specialist Social Worker, and the specialist R.N. This will need to be quite extensive, and will necessarily come under the supervision of persons who are well oriented and well trained in "Individual Differences."

Consultants to the Institution:

1. A Pediatrician.

2. One additional trained Social worker.

As already mentioned, the necessity of using untrained social workers serving under these two trained workers will need to be considered, as should also the feasibility of utilizing "Home Teachers" in this type of role.

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suggestions.

Such a program will necessarily involve years of development to bring it to function. I shall remain ready to present an outline of such a sequence for you at a later date.

For the present, I would note the equal or greater importance of the Educational and Home Strengthening aspects of this program, in comparison with the importance of its Institutional phase.

CONCLUSION:

As I look back on the many words used to convey to you a survey of the problem of "retardation" and its needs. I cannot help but be aware of the fact that this program may be regarded as impractical and idealistic.

Nevertheless, when we think of the 3,000 members of our small Island Society who are at present suffering from our neglect we must realize that it is well past time that we did get concerned about this problem.

We must also consider the possibility that it is really we who are the "socially incompetents"; we, supposedly intelligent persons, who can frustrate children of low learning ability by exposing them for years to ordinary classroom procedures; we who, at times, derive satisfaction from teasing them; we who are blind to the major stresses that such persons place on their parents and homes, stresses caused in large part by our own mishandling of the problem. It seems indeed,

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that it is we who have been irresponsible, and it is certainly we who are the losers. Having sown the wind we reap the whirlwind, in unhappy disturbed individuals; in an increasing burden of Multiple Problem Families; in an unproductive group of workers called the "no-goods"; in distressed families faced by distressing problems with their retarded sons or brothers, daughters or sisters.

Also in the light of present knowledge, we must appreciate the fact that while it is only by the sheerest of coincidence that we have been blessed with children of normal intelligence, others equally suited for this happy state by heredity, achievement and worth, are left by us with little or no help in dealing with the staggering problem presented by their "retarded child."

In view of all this we must conclude that such a program is neither "impractical" nor "idealistic". The problems presented by "Mental retardation" are very extensive and very, very real.

In our attempts to resolve these problems let us not lose ourselves in the natural satisfaction resulting from the erection of large, imposing, even well equipped (albeit usually understaffed) institutions; but let us also concern ourselves with the less glamorous task of providing educational opportunities, and an adequate well trained staff to meet the basic personal needs of our "retarded children" and their families. Then, and only then, will we be able to significantly alleviate the mal-effects of this widespread condition.

Yours truly, M.N.BECK,M.D.

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THE CHAIRMAN: Thank you, Mr. MacNaught. Does any one of your associates wish to add anything to what has been said by way of comment?

MR. MacNAUGHT: They are prepared to answer any questions that are asked.

DR. BECK: Not particularly, except one item as you were reading. Miss Comiskey, who is behind me, is a social worker working full time in retardation, and this implication does not seem to come out of the brief. She has just recently joined our services.

COMMISSIONER BALTZAN: Referring to paragraph 11, the last portion, it is submitted that where such a mentally retarded person cannot be designated as a dependent, provision should be made for hospitalization. Is that the right place generally for such a person, hospitalization in the terms that we look at hospitalization, especially where we are now extending the services of hospitals?

MR. MacNAUGHT: The point anticipated there is that the ordinary hospitalization, not per se mental hospitalization.

COMMISSIONER BALTZAN: I am just questioning whether that is the right place, as compared for instance with experiments and experiences in Denmark, where many of these are farmed out, as it were, and placed in private homes, where they receive a certain amount of remuneration for whatever little work, or the kind of work that they do.

DR. BECK: To answer the specific question,

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MR. MacNAUGHT: They are prepared to answer any questions that are asked.

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DR. BROCK: To answer the specific question,

and I have not been intimately involved in the preparation of this brief. There is no implication that I am apologizing for the brief, I am not. It is for my own ignorance. I feel that the point is the fact of the retarded person, who when he is thirty is still dependent on the family, but not listed as a dependent under the hospital insurance.

THE CHAIRMAN: He does not qualify as a dependent under the definition as presently appearing in the regulations?

MR. MacNAUGHT: That is right.

THE CHAIRMAN: Who takes sick and has to go to hospital, whether he breaks a leg or an arm, or whatever?

DR. BECK: Yes.

COMMISSIONER BALTZAN: But not for his state of retardedness?

MR. MacNAUGHT: No, for breaking his leg, as My Lord has mentioned, or for his appendix.

DR. BECK: I think this is inherent in my own presentation of this that I made to the Minister a couple of years ago, that first retarded children are better cared for in their own home, secondly, if they cannot be cared for in their own home, they are better cared for in a hospital than an institution, thirdly, we do need an institution for some retarded persons who cannot be cared for in either. Going along with the Denmark idea, and this foster home idea has been more ably developed in the Scandinavian countries and elsewhere, and I say to our

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own credit they have been better developed in Prince Edward Island than elsewhere.

COMMISSIONER FIRESTONE: Mr. MacNaught, does your Association for the Retarded Children of Prince Edward Island endorse the contents of the brief submitted by Dr. Beck to the Minister of Health for the province of Prince Edward Island in July 1959?

MR. MacNAUGHT: Yes.

COMMISSIONER FIRESTONE: In other words, this brief has not just been submitted to us for our information, but has also been submitted to us because it reflects and represents the considered views of your Association?

MR. MacNAUGHT: That is correct, absolutely.

DR. BECK: The reverse of what I have just said is not true. I have just said that I haven't participated in the preparation of this report. On the other hand, the local Association for Retarded Children was very active in the preparation of my report to the Minister.

COMMISSIONER FIRESTONE: I take it, Dr. Beck, that some progress has been made since July 1959 and November 1961 in implementing some of the recommendations contained in your report?

DR. BECK: Very definitely.

COMMISSIONER FIRESTONE: Would it be possible for the Association to let the Commission know what are some of the things that have not been implemented, so that we have an idea of the kind of program that you are recommending that still needs to

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COMMISSIONER FINNERTONE: Would it be possible for the Association to let the Commission know what are some of the things that have not been implemented, so that we can see how far the Land is [illegible]

be done?

DR. BECK: It is easier to start from the other end of that. What has been implemented is this, that we, since the report was written, we have a day training school. We have the construction of this 21 bed unit started, which is visualized as the first unit of maybe a three cottage unit. We are working by cottages. We will make one 21 bed one now. As the demand is demonstrated we will make another, and possibly another.

THE CHAIRMAN: All in the one location?

DR. BECK: Thinking has not jelled on this. The original intent in my report was that it be in the one location for easier administration. The Minister of Health is somewhat in favour of having one here, one west, and one east, and there is very considerable merit in his suggestion.

THE CHAIRMAN: Do you mean access by the parents to the child?

DR. BECK: Yes, and community feeling, and all these things that are so important in community life. We have since the report was written the day camp program, the institution facility here. We have in my viewpoint the assistance of Miss Comiskey as a social worker. We are also now just embarked on opening day training classes in the western Prince area, which is a somewhat modified program, but which will give some assistance in the O'Leary area. What has not been done is that we need more institutional facilities, more day training schools

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for the lower level retarded. I am sure we will demonstrate that we will need more than one social worker in this field. We imperatively need auxiliary classes. This is the type of class that is carried on within the ordinary school, where the child may advance at its own rate, rather than at the rate of the group. I think individual advancement classes is a better terminology for these.

COMMISSIONER FIRESTONE: Mr. MacNaught, would it be possible in consultation with Dr. Beck and whatever other people you feel that you should consult, to let the Commission have a brief indication of what some of the financial implications would be of that part of the program that has not as yet been implemented?

MR. MacNAUGHT: I am in consultation with Dr. Beck at this minute, and I believe in a general way we can submit some figures that would be helpful, but the actual cost, no we couldn't. I mean, this is in an experimental stage. This is a new problem. This has been ignored for centuries, and at least in this country it has only been the last decade that the surface of it has begun to be scratched, so to give any costs with any degree of accuracy of the program remaining to be implemented, I believe would only be in a very general way.

COMMISSIONER FIRESTONE: We understand your position, sir, but even a general statement with some indication of the financial implications would be helpful, so that we will know what would be

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involved if some of the things you are recommending were to be implemented?

MR. MacNAUGHT: We will endeavour to give you a general statement on that.

DR. BECK: I think we should do the same as we did with the Mental Health Association, an estimate of what the cost would be on present salary levels, and forward that to you, if that would be satisfactory?

COMMISSIONER FIRESTONE: This would be more than adequate, thank you.

THE CHAIRMAN: Have you any further observations to make, Mr. MacNaught, or your associates?

DR. BECK: Could I carry one point in here, which I deliberately left out at the last discussion, which is on the economic side. There is no problem to establish the economic losses through retardation. This is just simply tremendous, and this involves people from the time they are in the cradle on, and what it further involves, and I think this is the important thing from the health viewpoint, is a lot of family distress, which limits the productivity of the other members of the family when the retarded child in the home is not well handled. This is not a necessary consequence, but all too often it comes about.

COMMISSIONER FIRESTONE: Would it be possible, since you have some definite views on the subject, to let us have the views in writing?

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COMMISSIONER FITZSIMONS: This would be more than satisfactory.

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COMMISSIONER FITZSTONE: Would it be possible, since you have some definite views on the subject, to let us have the views in writing?

DR. BECK: They are in here sir.

COMMISSIONER FIRESTONE: They are, although they are not specifically spelled out as to the extent of these sort of losses which might be incurred. I thought that by drawing on your experience you may be able to give us some complete information as to the kind of economic losses. If you have any supplementary information on this subject, we certainly would appreciate it.

DR. BECK: I don't have anything more specific than what I have included here, other than this, which I can give you verbally. Our theoretical figures are that three per cent of children are retarded, 75 per cent of these are educable 20 per cent are trainable, and 5 per cent non-trainable. On the educable level there are figures in here of studies which we carried out with our liaison teachers in the Summerside area, which validate these figures. On the training level we are now able to substantiate our figure of 230 pretty well, because of the fact that from our diagnostic clinics we now know 150, and we can assume that the other 80 in the community, but to become more specific actually I cannot.

COMMISSIONER FIRESTONE: Thank you very much sir. That is very helpful.

THE CHAIRMAN: Thank you very much Mr. MacNaught and your associates with you here today.

Now this brings us to the end of the organizations which indicated an intention to make

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COMMISSIONER FIRESTONE: Thank you very much sir. That is very helpful.

THE CHAIRMAN: Thank you very much Mr. MacNaught and your associates with you here today.

Now this brings us to the end of the organizations which indicated an intention to make

submissions. Is there anyone present in the audience who wishes to make any submission, or make any statement?

If there is no one else who wishes to be heard, this brings us to an end of our public hearings in Prince Edward Island, and we will continue the public hearings in Fredericton tomorrow morning at 10:00 o'clock.

Before concluding, I want to express on behalf of the Commission our thanks to those who did accept the invitation to submit briefs, and to come forward with ideas and answers to questions. It is only by participation of all interested organizations and people that this Commission can hope to collect the information it must have in order to assess the very broad problems that have been presented to it to inquire into, and to recommend upon, and so I want again to thank those who did come before us here yesterday and today, and to assure you, to assure everyone, and all organizations that they have been most helpful to the work of the Commission. Thank you.

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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

FREDERICTON

N. B.

VOLUME NUMBER:

10

DATE:

NOVEMBER 9 1961

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Fredericton, N.B.,
9th day of November, 1961.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -------- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O. J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MAJ. N. LAFRANCE

MISS ALICE GIRARD, R.N.

DR. DAVID M. BRITTAIN

PROF. O. J. FIRESTONE

M. WALLACE McCUTCHEON, Q.C.

DR. ARTHUR F. VAN WART

DIRECTOR OF RESEARCH:

SECRETARY:

MAJ. N. LAMMAMOT

Fredericton, N.B.
Thursday,
November 9th, 1961.

--- On commencing at 10.00 a.m.

THE CHAIRMAN: Mr. Premier, ladies and gentlemen, as advertised, the Commission is in the Province of New Brunswick today and also tomorrow to hear submissions from those who wish to make their views known and to furnish information to the Commission set up by the Government of Canada to inquire into health services. We are anxious to be as fully informed as possible. We are going to all provinces because we wish to get additional to the view of Canada as a whole the views and particular problems and matters of concern provincially.

There is another and important and valid reason why it must give very careful consideration to the provincial viewpoint, and that is because under the British North America Act there is a division of powers, and basically health falls within provincial jurisdiction and, therefore, any programme of health services which could be evolved or recommended must necessarily take into consideration fully the provincial position and the fact of our constitutional position under the British North America Act.

The contribution which the federal authority might or could make must necessarily be limited to that of a financial contribution, because the administration of any health service naturally must remain in the provincial control, and I think it is particularly pleasing, Mr. Premier, to members of the Commission that

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you should honour us with your presence here this morning. It emphasizes what we already know: your profound interest in the welfare of the Province and in the consideration of this most important subject.

The hearing is now open for the reception of submissions as advertised.

THE HON. L. J. ROBICHAUD: Mr. Chairman of the Commission and members of the Commission, ladies and gentlemen, I might say at the outset that, of course, I am delighted to be here, but I have been asked to be here, and now that I am here I am extremely happy to have met with Chief Justice Hall again with whom I had come in contact in Winnipeg earlier this year. I came in contact, I should say, with all his charms, and I know as well that the other members of the Commission are very charming people. They are most welcome in New Brunswick. I do trust that the people who will appear before you will have been adequately prepared and will be in a position to let you know what the health picture of New Brunswick is at the present time.

I have been informed that yesterday in Prince Edward Island the Premier had claimed credit for the good weather. Perhaps I should do the same, because we enjoy today good weather.

Your presence here is very much appreciated, and whatever the federal government can do to help us in a health way, in a mental way, in an economic way, we will always appreciate.

Thank you, and may your stay in Fredericton be very enjoyable.

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Thank you, and may your stay in Fredericton be very enjoyable.

THE CHAIRMAN: Thank you very much, Mr. Premier.

We have prepared an agenda, and I will run through it. The first submission will be from the Minister of Health of the Province of New Brunswick. It will be followed by a submission from the Victorian Order of Nurses, then by the Maritime Hospital Services Association, the New Brunswick Psychiatrict Association, the New Brunswick Dental Society, the New Brunswick Dental Technicians Association. We will see how we progress as the day goes. We contemplate receiving the submission of the New Brunswick Medical Society at 9 o'clock tomorrow morning, to be followed by the Pharmaceutical Society, the New Brunswick Association for Retarded Children. However, if time permits, we will hear the Pharmaceutical Society this afternoon. Then, tomorrow, the Registered Nurses Association.

These are all the submission of which we have had notice, and of which copies have been filed. Others may wish to present briefs or file submissions while the Commission is here, and if they so desire they will get in touch with Mr. Lafrance, the Commission's Secretary.

We are prepared to proceed with the submissions from the Minister of Health of the Province of New Brunswick, Dr. Dumont.

Mr. Premier,

We have prepared an agenda, and I will run through it. The first submission will be from the Minister of Health of the Province of New Brunswick. It will be followed by a submission from the Victorian Order of Nurses, then by the Maritime Dental Society, Association, the New Brunswick Psychiatric Association, the New Brunswick Dental Society, the New Brunswick Dental Technicians Association. We will see how we progress as the day goes. We contemplate receiving the submission of the New Brunswick Medical Society at 5 o'clock tomorrow morning, to be followed by the Pharmaceutical Society, the New Brunswick Association for Retarded Children. However, if time permits, we will hear the Pharmaceutical Society this afternoon. Then tomorrow, the Registered Nurses Association.

These are all the submissions of which we have had notice, and at which copies have been filed. Others may wish to present briefs or file submissions while the Commission is here, and if they so decide they will get in touch with Mr. Lafrance, the Commissions Secretary.

We are prepared to proceed with the submissions from the Minister of Health of the Province of New Brunswick, Dr. Lamont.

SUBMISSION

OF

THE DEPARTMENT OF HEALTH, PROVINCE OF NEW BRUNSWICK

APPEARANCES:

The Hon. Georges L. Dumont, M.D.,

-- Minister of Health

C. W. Kelly, M.D., C.M.,

-- Director, Health Planning Services.

--- EXHIBIT NO. 36: Brief of Department of Health, Province of New Brunswick.

DR. DUMONT: Mr. Chairman, members of the Commission, Mr. Premier, ladies and gentlemen, it has been suggested that it might be appropriate that in my opening remarks, since you have a tender spot in your heart, Mr. Chairman, for the French language that I should express myself and address to you a few words of greeting in French.

Je suis particulièrement heureux de vous saluer M. le Président et de vous acceuillir au nom de notre Département de la Santé. Nous sommes très heureux de nous présenter devant la Commission et vous faire rapport. Nous sommes certainement anxieux de collaborer avec notre Commission et nous ferons tout en notre pouvoir pour vous exposer nos points de vue sur la situation des soins medicaux qui existent dans notre province.

I would like now, Mr. Chairman, in my opening remarks to suggest to you that this voluminous report that the Department of Health is now today present-

--- EXHIBIT NO. 36. Pub. of Department of Health, Province of New Brunswick.

DR. DUMONT: Mr. Chairman, members of the Commission, Mr. Premier, ladies and gentlemen, I have been suggested that it might be appropriate that in my opening remarks, since you have a tender spot in your heart, Mr. Chairman, for the French language that I should express myself and address to you a few words of greeting in French.

Je suis particulièrement heureux de vous saluer M. le Président et de vous accueillir au nom de notre Département de la Santé. Nous sommes très heureux de nous présenter devant la Commission et vous faire avec notre Commission et nous ferons tout en notre pouvoir pour vous exposer nos points de vue sur la situation des soins médicaux qui existent dans notre province.

I would like now, Mr. Chairman, in report that the Department of Health is now today present

ting is not the sole effort of your humble servant as Minister of Health. I must give credit to the heads of our divisions, and chiefly to one close to me on the left here, Dr. Kelly, who has given considerable time and effort to correlate and put together all these reports from the different departments.

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INDEX

INDEX

INTRODUCTION

1. The Department of Health, Province of New Brunswick is organized in Divisions for the purpose of administration and health services. The personnel of each division is responsible to the Director of the Division, who, in turn, is responsible to the Chief Medical Officer and through him to the Minister of Health.

The Divisions are as follows:

(a) Health - Vital Statistics
- Health Planning Services

(b) Accounting

(c) Hospital Services

(d) Mental Health Services

(e) Tuberculosis Service

(f) Child and Maternal Health Services

(g) Dental Health Services

(h) Rehabilitation Services

(i) Cancer Control Services

(j) Communicable Disease Control Services

(k) Public Health Nursing Service

(l) Sanitary Engineering Service

(m) Health Education Services

(n) Provincial Laboratory Services

(o) District Medical Health Officers

Due to the fact that all health services provided or assisted from public funds are administered under the foregoing plan of organization, it was felt desirable to prepare this submission in sections, each related to one or more Division of the Department of Health.

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The Divisions are as follows:

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- Health Planning Services

(b) [illegible]

(c) Hospital Services

(d) Mental Health Services

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(f) Child and Maternal Health Services

(g) [illegible]

(h) [illegible]

(i) Cancer Control Services

(j) [illegible]

(k) [illegible]

(l) Sanitary Engineering Service

(m) [illegible]

(n) Provincial Laboratory Services

(o) District Medical Health Officers

Due to the fact that all health services provided or assisted from public funds are administered under the foregoing plan of organization, it was felt desirable to prepare this submission in sections, each related to one or more Division of the Department of Health.

2. The following sets forth a summary of the chief conclusions contained in the body of this submission.

(a) The National Health Grants have been of valuable assistance to the province in extending existing health services and initiating new services. Expenditures from these grants (exclusive of the Hospital Construction Grant) in 1960 were $1,185,800.00 or 92% of the available grants. The Hospital Construction Grant was completely allotted but projects were not completed within the year and thus the grant was not completely claimed but remains available. The principle of allotting, related in part to a per capita basis, has resulted in an annual reduction in many of the grants to New Brunswick. This is due, of course, to the fact that the richer provinces are having a proportionately greater annual increase in population. This means to a certain extent, that the money is being diverted from the economically poor provinces to the richer ones, without regard to fiscal need.

(b) The qualified District Medical Health Officers are in short supply. We have 4 fully qualified and two physicians in an acting capacity. The full complement required would be a total of 9 fully qualified individuals. The Public Health Nursing Service requires an additional 45 qualified public health nurses. The adult poliomyelitis immunization program requires more emphasis and expansion at this time.

(c) The mental health services of the province are deficient in trained professional personnel and community psychiatric clinics. The mental hospital

chief conclusions contained in the body of this submission.

(a) The National Health Grants have been a valuable assistance to the provinces in extending existing health services and initiating new services. Expenditures from these grants (exclusive of the Hospital construction grant) in 1960 were $21,185,000.00 or 99% of the allotted grants. The Hospital Construction Grant was completely allotted but projects were not commenced within the year and thus the grant was not completely claimed but remained available. The principle of allotting, related in part to a per capita basis, has resulted in an annual reduction in many of the grants to New Brunswick. This is one, of course, to the fact that the number provinces are partic o proportionately greater annual increase in population. This means to a certain extent, that the money is being diverted from the economically poor provinces to the

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(c) The mental health services of the province

facilities are in need of additional bed space and future consideration should be given to additional psychiatric sections in general hospitals. It has long been recognized that there is a need for psychiatric facilities for mentally disabled and retarded children. This problem is now in the planning stage.

(d) Reference is made to the graph contained in Section D of the submission, from this it will be noted that great strides have been made in this segment of health care. Bed facilities are now being converted from this service to general hospital facilities.

(e) Hospital facilities in active treatment general hospitals of the province are improving annually and will reach the point of being adequate by 1965. New construction now in progress will provide 263 beds. Conversion from Tuberculosis Service will immediately provide 190 beds and extensions to existing hospitals and replacement of obsolete structures, with larger modern structures will provide a net gain of 212 beds. This would provide a complement of 3759 beds in general hospitals by the end of 1965. Bed needs in the chronic and convalescent hospital are required. It is estimated that 990 such beds should be provided by 1965. Homes for the Aged and Nursing Homes, which are a responsibility of the Department of Welfare in this province, require additional facilities. The future needs in this service are estimated at an additional 650 beds in Homes for the Aged and an additional 343 beds in Nursing Homes.

(f) The segment of health services related to children and mothers is a very important one. The section

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(d) Reference is made to the graph contained in Section D of the submission, from which it will be noted that great strides have been made in this aspect of health care. Bad facilities are now being converted from this service to general hospital facilities.

(e) Hospital facilities in active treatment general hospitals of the province are improving annually and will reach the point of being adequate by 1965. New construction now in progress will provide 1,5 beds. Conversion from Tuberculosis Service will immediately provide 1,500 beds and additions to existing hospitals and replacement of obsolete structures, with larger modern structures will provide a net gain of 4,000 beds. This would provide a complement of 3,500 beds in general hospitals by the end of 1965. Bed needs in the chronic and convalescent hospital are required. It is estimated that 900 such beds should be provided by 1965. Homes for the Aged and Nursing Homes, which are a responsibility of the Department of Welfare in this province, require additional facilities. The future needs in this service are estimated at an additional 650 beds in Homes for the Aged and an additional 2,5 beds in Nursing Homes.

(f) The segment of health services related to

on this item is very extensive in view of the fact that at the present time 61% of our population is composed of mothers in the child bearing age and children up to 19 years of age. By 1971 we estimate this group will form 64% of our population. Healthy children is the most valuable asset of any country and we cannot have healthy children without healthy mothers. The conclusions and recommendations reached in this section are too numerous for comment here.

(g) Medical rehabilitation facilities require expansion at this time. We require the expansion of an existing centre to provide 40 additional beds. One new centre to serve the north of the province with out-patient facilities and 60 new beds. Establishment of physiotherapy departments at 8 general hospitals and a mobile assessment clinic to serve the province. Additional staff required for this expansion would be one doctor trained as a specialist in Physical Medicine and an additional 39 trained physiotherapists, some of which should be bi-lingual.

(h) Cancer services are now considered fairly adequate and no suggestions are offered at this time.

(i) To provide this service to the population of the province, requires a marked expansion. The ratio of dentists to population is 1:5175, while the national average is 1:3018. Dental service for children requires the establishment of 25 dental clinics, as well as, an extensive training program for professional personnel to alleviate the shortage of trained individuals. The annual cost of a complete dental care program excluding 50% of the cost of artificial dentures is estimated at

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(g) Medical rehabilitation facilities require expansion at this time. We require the expansion of an existing centre to provide 50 additional beds. One new centre to serve the north of the province with out-patient facilities and 50 new beds. Establishment of physiotherapy departments in 6 general hospitals. One mobile assessment clinic to serve the province. [illegible] al staff required for this expansion would be one [illegible] trained as a specialist in Physical Medicine and [illegible] ditional 30 trained physiotherapists, some of which

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$2,920,000.00 or a per capita cost of $5.45.

(j) The provincial laboratory service provides public health and clinical laboratory service to all hospitals and public health functions in the province except D.V.A. Hospital at Lancaster. Expansion of facilities are required as well as additional Pathologists. One new regional laboratory is required at an estimated cost of $190,000.00. Additional equipment in 12 hospital laboratories at a total estimated cost of $50,000.00. Additional staff required would be 4 Pathologists and 11 Laboratory Officers trained at University level.

(k) The post-graduate training of health personnel has been assisted substantially by the Department of Health during the past 10 years. Annual expenditures on this item are averaging $250,000.00. There has been a total of 720 health personnel trained with this assistance over the past 10 years. Facilities exist in this province for training nurses, nurse assistants, laboratory technicians and X-ray technicians. There is also some resident training facilities in Psychiatry, Pathology, Radiology and Interne Training. Nurses on the active register in New Brunswick in 1960 were 2163 and in 1961 were 2304. All nursing personnel in general hospitals at this time show an excess of 43 over the standard requirement. In 1958 statistics indicate that the ratio of nursing personnel to patients was higher in New Brunswick than any other Province of Canada except Ontario. There is a total of 486 registered physicians with an additional 7 at D.V.A. Hospital, Lancaster not registered in the province. The ratio of

$2,020,000.00 or a per capita cost of $3.45.

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(k) The post-graduate training of health personnel has been assisted substantially by the Department of Health during the past 10 years. Annual expenditures on this item are averaging $40,000.00. There has been a total of 180 health personnel trained with this assistance over the past 10 years. Facilities exist in this province for training nurses, nurse assistants, laboratory technicians and X-ray technicians. There is also some resident training facilities in Psychiatry, Pathology, Radiology and Inverse Therapy. Nurses on the active register in New Brunswick in 1951 were 2165 and in 1961 were 2904. All nursing personnel in general hospitals at this time show an excess of 47 over the standard requirements. In 1958 statistics indicate that the ratio of nursing personnel to patients was higher in New Brunswick than any other Province of Canada except Ontario. There is a total of 480 registered

doctors to population is 1: 1238. The ratio in 1951 was 1: 1530. The national average at the present time is 1:888. The total number of medical doctors are divided in categories as follows:

There are 99 doctors on full time salary.

There are 389 doctors in private practice of medicine, of which, 154 are qualified as specialists and 235 are general practitioners. Please refer to tables and sketch map in Section K of the submission for distribution of medical manpower.

(l) There are eight voluntary agencies that provide certain services to individuals in the health field, however, there are many more who are actively engaged in the field of health education and public relations.

(m) Prescription drugs are all provided in hospitals of the province. These were provided in 1960 at a cost of $1,263,000.00 from public funds, included in this amount was the drug costs at D.V.A. Hospital, Lancaster. This total resulted in an expenditure of $2.04 per capita. It is further estimated that the provision of prescription drugs outside hospital, excluding vitamin preparations would cost $1,922,000.00 annually or a per capita cost of $3.10. This estimate is based on the assumption that generic, chemical or non-proprietary nomenclature might be instituted which we feel might result in an appreciable saving on this service. It is to be noted then that provision of drugs for in-patients and for the population outside hospital would be an estimated cost of $3,185,000.00 or a per capita cost of $5.14.

1: 1530. The national average at the present time is 1:888. The total number of medical doctors are divided in categories as follows:

There are 90 doctors on full time salary.

There are 489 doctors in private practice of medicine, of which, 194 are qualified as specialists and 295 are general practitioners. Please refer to tables and answer key in section 5 of the submission re distribution of medical manpower.

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(n) Section N in the submission deals with the costs of health services presently not provided from public funds. These are set forth in three segments and listed according to priority.

Priority I - It is estimated that to provide a complete Maternity Care Plan would cost a total of $1,638,000.00 in 1962 or a cost of $2.64 per capita of total population.

Priority II - It is estimated that to provide a complete Medical Care Plan for all children up to the seventeenth brithday would cost a total of $4,860,800.00 in 1962 or a cost of $7.84 per capita of total population.

Priority III - It is estimated to provide a complete Medical Care Plan for all the population, excluding those covered by present Acts of Federal and Provincial jurisdiction, would cost a total of $12,341,000.00 or a cost of $19.90 per capita of the total population. The above estimates include the cost of prescription drugs outside hospital. In any future extension of health services provided from Provincial public funds, it is hoped that substantial assistance from the Government of Canada would be provided, giving due regard to the fiscal need of the area or province concerned. At the present time all health services from public funds, excluding the Department of Veterans' Affairs Hospital, Lancaster, N.B., are being provided at a per capita cost of $50.45, of which a per capita of $13.17 is recovered from the Government of Canada. To provide complete health services would cost an additional

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$25.35 per capita. In the event of this provision, it is hoped a substantial portion of this per capita cost might be recovered from the Government of Canada as assistance.

SECTION A

UTILIZATION OF NATIONAL HEALTH GRANTS IN NEW BRUNSWICK

The National Health Grants were initiated by the Federal Government through its Department of National Health and Welfare. The effective date was April 1, 1948. The purpose ofthese grants was to provide assistance to the various provincial governments in extending existing health services and providing new health services for the people of each province.

This report and its statistics cover the fiscal year of 1960-61, that is, a period from April 1, 1960 to March 31, 1961. The figures provided are rounded to the nearest hundred.

NON MATCHING GRANTS

Expenditures from these grants are claimed by the province one hundred per cent up to the maximum of the grant.

(a) Professional Training $85,500.00 Amount of Grant
Expenditure, $71,700.00 Per Cent of Grant, 83%

This expenditure was utilized in the training of personnel employed in active treatment general hospitals.

UTILIZATION OF NATIONAL HEALTH GRANTS IN NEW BRUNSWICK

The National Health Grants were initiated by the Federal Government through its Department of National Health and Welfare. The effective date was April 1, 1948. The purpose of these grants was to provide assistance to the various provincial governments in extending existing health services and providing new health services for the people of each province.

year of 1950-51, that is, a period from April 1, 1950 to March 31, 1951. The figures provided are rounded to the nearest hundred.

Expenditures from these grants are limited to the province one hundred per cent up to the maximum of the grant.

Expenditure, $71,000.00 Per Cent of Grant, 64%

This expenditure was utilized in the training of personnel employed in active treatment general hospitals.

(b) Mental Health $312,800.00 Amount of Grant
Expenditure, $312,800.00 Per Cent of Grant, 100%

The above is made up of $42,000.00 for post-graduate training of mental health personnel. The remainder provided for the operation of four regional mental health clinics and the service in Psychology and Psychiatric Social Work at our two large mental hospitals in the province.

This grant provided 10% of the total cost of mental health services in New Brunswick.

(c) Tuberculosis Control $157,500.00 Amount of Grant
Expenditure, $157,500.00 Per Cent of Grant, 100%

This expenditure provided anti-tuberculous drugs to the extent of $29,000.00. The operation of ten diagnostic clinics and the control centre at $34,000.00. The provision of a Regional Tuberculosis Consultant Service at $14,000.00 and the remainder was used to provide a rehabilitation service in the four treatment institutions of the province.

(d) General Public Health $504,500.00 Amount of Grant
Expenditure, $461,700.00 Per Cent of Grant, 91%

Training of public health personnel to the extent of $73,000.00.

Equipment for University School of Nursing, $13,000.00.

Salaries and travel of public health nursing personnel, $165,000.00. Sanitation services, $53,000.

Public health laboratory tests on milk and water, $17,000.00.

Consultant service to hospitals under the

The remainder provided for the operation of four regional mental health clinics and the service in Psychology and Psychiatric Social Work at our two large mental hospitals in the province.

This grant provided 10% of the total cost of mental health services in New Brunswick.

(c) Tuberculosis Control $157,500.00 Amount of Grant Expenditure, $187,500.00 Per Cent of Grant, 100%

This expenditure provided anti-tuberculosis drugs to the extent of $89,000.00. The operation of ten diagnostic clinics and the control centre at $44,000.00. The provision of a Regional Tuberculosis Consultant Service at $14,000.00 and the remainder was used to provide a rehabilitation service in the four treatment institutions of the province.

(d) General Public Health $504,500.00 Amount of Grant Expenditure, $461,700.00 Per Cent of Grant, 94%

Training of public health personnel to the extent of $73,000.00.

Equipment for University School of Nursing, $13,000.00.

Salaries and travel of public health nursing personnel, $165,000.00. Sanitation services, $33,000.

Public health laboratory tests on milk and water, $17,000.00.

Consultant service to hospitals under the

Hospital Service Plan, $38,000.00.

Poliomyelitis vaccine, $23,000.00.

Glaucoma and Auditory Clinic $12,000.00.

Venereal Disease Control, $13,000.00.

Laboratory Services, $7,000.00.

Assistance to the Canadian Council on Hospital Accreditation, $1,000.00.

Paediatric Diagnostic and Therapeutic Clinics, $3,600.00.

The remainder was expended on several small items in the public health field.

(e) Child and Maternal Health $76,500.00 Amount of Grant

Expenditure, $42,100.00 Per Cent of Grant, 55%

This expenditure provided for the direction of the program in the field of nutrition and health to the extent of $28,000.00. The training of a nutritionist $1,000.00 and post-graduate training of professional personnel in the field of child and maternal health to the extent of $13,000.00.

MATCHING GRANTS

Any claim from these grants requires that an equal and matching expenditure be made by the province.

(f) Hospital Construction $1,411,600.00

Expenditure, $508,000.00 Per Cent of Grant, 36%

The amount of this Grant is made up of two parts. One part of $590,000.00 which is the grant for the year under review, while the remainder is money revoted from previous years which is allotted to hospital construction projects which are under construction but

tal Service Plan, $28,000.00.

Assistance to the Canadian Council on Hospital Accreditation, $1,000.00.

Psychiatric Diagnostic and Therapeutic Clinics, [illegible]

The remainder was expended on several small items in the public health field.

(e) Child and Maternal Health $76,[illegible].00 Amount of [illegible]

This expenditure provided for the extension of the program in the field of nutrition and health to the extent of $28,000.00. The hiring of a nutritionist at $1,000.00 and part-time teaching or professional personnel in the field of child and maternal health to the extent of $12,000.00.

MAINTENANCE

Apart from these grants, provision was made for equal and matching expenditures to come by the provinces.

(f) Hospital Construction $1,[illegible].00

Expenditure, $[illegible].00 Per Cent of Items, [illegible]

The amount of the Grant is made up of two parts:- One part of $500,000.00 which is the grant for the year under review, while the remainder is money revoted from previous years which is allowed to hospitals for construction projects which are under consideration for

which have not been completed.

(g) Cancer Control $70,000.00 Amount of Grant

Expenditure, $62,500.00 Per Cent of Grant, 89%

A portion of this amount to the extent of $12,500.00 was given to the National Cancer Institute to assist in research. The remainder was utilized to assist the province in providing diagnostic service for cancer at six clinics, out-patient X-ray and biopsy service, the service of consultants and all types of radiotherapy on an out-patient basis.

Effective March 1, 1961, this service has been extended to include the provision of medical, surgical, anaesthetic and consultant fees for service on all cases of proven malignant neoplasm, while such cases are in-patients of approved active treatment general hospitals. It is estimated the cancer control program will not cost the province $250,000.00 annually, half of which will be claimed from the federal source under the grants program.

PARTIALLY MATCHING GRANTS

Expenditures from these grants may be claimed one hundred per cent for training and equipment, while the service to individuals is on a matching basis.

(h) Medical Rehabilitation & Crippled Children $95,000.00 Amount of Grant

Expenditure, $77,500.00 Per Cent of Grant, 81%

Training of personnel was provided to the extent of $12,500.00 and $65,000.00 was claimed from the grant to assist the province in providing rehabilitation

Expenditure, $62,500.00 Per Cent of Grant, 59%

A portion of this amount to the amount of $12,500.00 was given to the National Cancer Institute to assist in research. The remainder was utilized to assist the province in providing diagnostic service for cancer at six clinics, out-patient X-ray and biopsy service, the service of consultants and all types of radiotherapy on an out-patient basis.

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PARTICIPATING MATERNITY CENTRE

Expenditures from these grants may be claimed one hundred per cent for training and equipment, while the service to individuals is on a matching basis.

(b) Medical Rehabilitation $65,000.00 Amount of Grant & Original Estimate

Expenditure, $77,500.00 Per Cent of Grant, 81%

Training of personnel was provided to the extent of $12,500.00 and $65,000.00 was claimed from the

services to disabled individuals on a fee for service basis, after physical and financial assessment of the disabled persons.

GENERAL ASPECTS OF THE NATIONAL HEALTH GRANTS

The Department of National Health and Welfare has repeatedly reminded the provinces that the purpose of National Health Grants is to assist the provinces in providing new and extended health services to their people. The general idea expressed is that the money must not be viewed as a mere handout but that the province must do its share. A second hope expressed by The Department at Ottawa is that the services assisted from National Health Grants should not be kept separate from provincial health services but should be so merged with them as to be undistinguishable. It is felt that this is an excellent principle of operation.

The Province of New Brunswick has carried out fully its responsibility in paying its share of the extension of health services provided from public funds.

There is no doubt that National Health Grants, either through desire or necessity, has resulted in a marked expansion of health services in this province during the past thirteen years.

The principle of allotting these grants related in part to a per capita basis, has resulted in an annual reduction in many of the grants, due, of course, to the fact that the richer provinces are having a proportionately greater annual increase in population. This means to a certain extent, that the money is being diverted from the economically poor provinces to the richer ones.

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The principle of allotting these grants related in part to a per capita basis, has resulted in an annual reduction in many of the grants, due, of course, to the fact that the richer provinces are having a proportionately greater annual increase in population. This means to a certain extent, that the money is being diverted

The regulation imposing a 75% limit of the grant for recurring expenditures has caused difficulties in the province. This means that 25% of these grants must be used on non-recurring or new expenditures each year. This, in fact, has resulted many times in services which were initiated under National Health Grants becoming a responsibility of the provincial treasury, so that 25% of the grant would remain for new services. It is obvious that when this goes on indefinitely, it can bring about a disturbing financial penalty for the province.

The total of all National Health Grants available to the province for the present year is $1,895,000.00, while the provincial expenditure from public funds for health services, excluding hospital services under the Federal - Provincial Hospital Service Plan, is estimated at approximately $12,000,000.00. Thus it is evident that Federal assistance given under National Health Grants will provide approximately 15% of this cost in the present year.

SECTION B

PUBLIC HEALTH AND PREVENTIVE MEDICINE

1. The Province of New Brunswick is divided into six health districts. In each of these districts there is a medical health officer. The responsibility of these medical officers is to direct and carry out the program of prevention in their respective districts. Four of these doctors are qualified by Diploma in Public

The regulation imposing a 75% limit of the grant for recurring expenditures has caused difficulties in the province. This means that 25% of these grants must be used on non-recurring or new expenditures each year. This, in fact, has resulted many times in services which were initiated under National Health Grants becoming a responsibility of the provincial treasury, so that 25% of the grant would remain for new services. It is obvious that when this goes on indefinitely, it can bring about a disturbing financial penalty for the province.

The total of all National Health Grants available to the province for the present year is $1,895,000.00, while the provincial expenditure from public funds for health services, excluding hospital plan, is estimated at approximately $12,000,000.00. Thus it is evident that Federal assistance given under National Health Grants will provide approximately 15% of this cost in the present year.

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Health and the remaining two are physicians experienced but not qualified in Public Health. Each medical officer acts as chairman of the county boards of health of the counties within his district. There are 15 county boards of health within the Province. The medical officer service is presently being provided from public funds at an annual cost of $100,000.00. To provide a more adequate service to the people of the province, it would require a total of 9 qualified medical officers and additional related office personnel. It is estimated that the future annual cost of this service, after expansion, would be $160,000.00.

2. The public health nursing service is provided by the Department of Health, the Victorian Order of Nurses, the Red Cross Society and in one area by the city and county board of health. In one area, a nurse is provided by The Tuberculosis Association and in another area one nurse is provided by the Gyro Club. The following lists the nursing personnel in public health and the responsible agency:

	Full Time	Half-Time
Department of Health	48	4
Victorian Order of Nurses	40	-
Red Cross Society	7	-
Tuberculosis Association	3	-
Gyro Club	1	-
Industrial Health	9	-
Saint John Board of Health	10	-
Total	118	4

but not qualified in Public Health. Each medical officer acts as chairman of the county boards of health of the counties within his district. There are 15 county boards of health within the Province. The medical officer service is presently being provided from public funds at an annual cost of $100,000.00. To provide a more adequate service to the people of the province, it would require a total of 9 qualified medical officers and additional related office personnel. It is estimated that the future annual cost of this service, after expansion, would be $160,000.00.

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Victorian Order of Nurses	40	-
Red Cross Society	7	-
Gyro Club	1	-
Industrial Health	9	-
Saint John Board of Health	10	-
Total	118	4

The Department of Health expenditure for Public Health Nursing Service under its division in the year of 1960 was $299,000.00, of this amount $165,000.00 was claimed from National Health Grants. In addition, the Department provided grants in aid to the Victorian Order of Nurses in the amount of $31,250.00 and $1,400.00 to the Red Cross Nursing Service. The remaining costs were provided chiefly by one municipality, undistry, Victorian Order of Nurses, Tuberculosis Society and Red Cross Society. From the above statistics on personnel, it will be noted that there are 118 full time public health nurses from all sources and 4 half-time nurses, which would be equal to 120 full time nurses. If we take a minimum standard of one public health nurse to each 4,000 population, then th s province will require a total of 165 nurses in public health by 1965. This will require an additional 45 qualified public health nurses. It is estimated to provide this desired expansion, it would cost approximately $198,000.00 annually in addition to the present expenditure on this service. We feel we must have much more integration of hospital and community services. As a prelude to this, there should be better co-ordination and integration within our own Department of Health. There should be an increase in home care services for the sick, especially in the non-urban areas. Such programs might be supplied by increasing V.O.N. services to the rural areas or adding this type of service to that already carried by our public health nurses. Many more clinic and out-patient hospital services are needed. It would appear to be more economical to run services on a

The Department of Health expenditure for Public Health Nursing Service under its division in the year of 1960 was $229,000.00, of this amount $165,000.00 was claimed from National Health Grants. In addition, the department provided grants in aid to the Victorian Order of Nurses in the amount of $31,290.00 and $1,400.00 to the Red Cross Nursing Service. The remaining costs were provided chiefly by one municipality, namely, Victorian Order of Nurses, Tuberculosis Society and Red Cross Society. From the above statistics on personnel, it will be noted that there are 118 full time public health nurses from all sources and 4 half-time nurses, which would be equal to 120 full time nurses. If we take a minimum standard of one public health nurse to each 4,000 population, then th a province will require a total of 165 nurses in public health by 1965. This will require an additional 45 qualified public health nurses. It is estimated to provide this desired expansion, it would cost approxi-

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Health Unit rather than on a County basis. Geographical boundaries make for greater travelling and more wear and tear on staff, because of duplication of reports, etc.

3. The communicable disease prevention program provided from public funds is directed by the Division of Communicable Disease Control. This service maintains a main biological depot and 28 sub-depots located through-out the Province. These depots provide 23 separate and distinct biological preparations, the major portion of which is without charge to the patient or the physician. The physician in private practise may and usually does make a charge for his professional service. Programs in immunization carried out by the Department of Health are entirely free to the patient. The biological service is provided annually at a cost of approximately $105,000.00. Approximately 20% of this cost is claimed from National Health Grants.

4. The basic immunization program is for children and provides immunization against diphtheria, whooping cough, tetanus and poliomyelitis. Family physicians also carry out immunization on individual children patients. The adult immunization program against poliomyelitis is conducted by the Poliomyelitis Foundation with the Department of Health providing the vaccine. Despite repeated and concentrated efforts on the part of our public health personnel, there still remains some children in our province who have not availed themselves of the opportunity to be immunized against poliomyelitis.

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There are approximately 40,000 adults in the younger age groups who have received protection against this disease. The following table reflects the morbidity and mortality state relative to poliomyelitis in this Province in 1960.

Age Distribution and Vaccination Status

Age	No. of Cases	Deaths	Remarks
0-5 yrs	20	0	4- one injection, 3-two injections, 1-three injections, 12-unknown.
5-10 yrs	26	1	4-one injection, 3-two injections, 2-three injections, 17-unknown. One death had no injections.
10-15 yrs	24	0	2-one injection, 1-two injections, 21-unknown.
15-20 yrs	10	1	1-two injections, 9-unknown. One death had two injections.
20-39 yrs	10	0	No vaccination.
40-59 yrs	1	0	No vaccination.
Total	91	2	

5. The aim of the Venereal Disease Control Service of the Department of Health is to decrease the incidence and limit the spread of venereal infection by the following methods:

(a) Confidential reporting of cases on the National Notification Card (Form N.H. 1) by physicians.

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Age Distribution and Vaccination Status

Age	No. of Cases	Deaths	Remarks
[illegible] yrs	20	0	4- one injection, 3-two injections,
[illegible] yrs	26	1	4-one injection, 3-two injections, 2-three injections, death had no
10-15 yrs	24	0	2-one injection, 2-[illegible]
15-20 yrs	10	1	1-two injections, One death had two injections.
20-39 yrs	10	0	No vaccination.
40-59 yrs	1	0	No vaccination.
Total	91	2	

The aim of the Venereal Disease Control Service of the Department of Health is to decrease the incidence and limit the spread of venereal infection by the following methods:

(a) Confidential reporting of cases on the [illegible] by physicians.

(b) Provision of current information on diagnosis and treatment to physicians on request and educational material to the general public.

(c) Provision of free antibiotics for the treatment of all cases and payment to the physicians for professional services.

(d) INvestigation of contacts.

(e) Compilation of statistical data.

In the major city of the province which is an ocean port, this Department provides a Social Hygiene Clinic which provides diagnosis, treatment and contact investigation for a population of 84,000 people, in the remainder of the province this service is provided by local physicians and public health nurses. This service was provided in 1960 at a cost of $27,000.00 and 50% of this cost is claimed from National Health Grants. From statistics available, it is anticipated that there will be no marked increase in this problem in the future, therefore, no increase in expenditures is anticipated. The following statistics will be of interest in conveying the Communicable Disease picture as it stands in New Brunswick at the present time.

Notifiable Diseases

1959	Disease	Number of Cases Reported in 1960	Deaths
13	Dysentery	4	
	amoebic	1	
13	bacillary	3	
89	Influenza (epidemic)	51	29

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In the major city of the province which is an ocean port, this Department provides a Social Hygiene Clinic which provides diagnosis, treatment and contact [illegible]

the remainder of the province this service is provided by local physicians and public health nurses. This service was provided in 1960 at a cost of $8\,000.00 and 50% of this cost is claimed from National Health Grants. From statistics available, it is anticipated that there will be no marked increase in this problem in the future, therefore, no increase in expenditures is anticipated. The following statistics will be of interest in conveying the Communicable Diseases picture as it stands in New Brunswick at the present time

Notifiable Diseases

1959	Disease	Number of Cases Reported in 1960	Deaths
13	Dysentery amoebic	4	
13	bacillary	1	
89	Influenza (epidemic)	51	29

102	Hepatitis (infectious)	82	4
7	Meningitis (meningococcal)	9	1
22	Meningitis (benign aseptic)	22	
62	Poliomyelitis (paralytic)	91	2
57	Scarlet Fever & Streptococcal Sore Throat	189	1
479	Tuberculosis, all forms	443	20
415	pulmonary	410	
64	non-pulmonary	33	
9	Typhoid and Paratyphoid Fever	3	
330	Venereal Disease - all forms	332	
280	gonorrhoea	317	
50	syphilis	15	
2	Encephalitis (infectious)	2	2
73	Food Poisoning	7	
13	Whooping Cough	19	3
1	Tetanus	1	1

(Total Syphilis (N.B. 1960)

	Male	Female
Primary	3	1
Secondary	0	1
Latent	0	5
Cardiovascular	1	0
Neurosyphilis	0	1
Prenatal (congenital)	0	3
Total	4	11

Age Distribution, Syphilis (N.B. 1960)

Age (years)	Reported Cases
Below 20	2
20-30	4

Hepatitis (infectious)	82	4
Meningitis (meningococcal)	9	1
Poliomyelitis (paralytic)	91	2
Sore Throat	189	1
Tuberculosis, all forms	443	20
pulmonary	410	
non-pulmonary	33	
Typhoid and Paratyphoid fever	3	
Venereal Disease - all forms	339	
gonorrhoea	317	
syphilis	22	
Encephalitis (infectious)	2	2
Food Poisoning	7	
Whooping Cough	19	3

Typical Results [illegible]

	Male	Female
Secondary	0	1
Latent	0	5
Cardiovascular	1	0
[illegible]	[illegible]	[illegible]
Prenatal (congenital)	0	3
Total	4	11

Age Distribution, Syphilis (N.B. 1960)

Age (years)	Proportion (%)
Below 20	2
20-30	4

30-40	5
40-50	0
50-60	1
60 plus	2
Unstated	1
Total	15

Age and Sex Distribution, Gonorrhoea (N.B. 1960)

Age (years)	Female	Male	Total
10-15	2	0	2
15-20	34	79	113
20-25	14	93	107
25-30	7	28	35
30-50	6	36	42
60 plus	0	0	0
Unstated age	6	12	18
Totals	69	248	317

Venereal Disease in New Brunswick (1944 - 1960)
Estimated Population 1960 - 604,000

Year	Rate per 100,000 population	
	Syphilis all Types	Gonorrhoea
1944	124.0	197.6
1945	88.2	230.6
1946	69.6	172.9
1947	61.7	132.2
1948	70.6	95.4
1949	75.0	100.2
1950	50.8	79.1
1951	33.5	71.4
1952	24.1	25.5

30-40	5
40-50	0
50-60	1
60 plus	2
Total	15

Age and Sex Distribution, Gonorrhoea (N.B. 1960)

Age (years)	Male	Female	Total
10-15	2	0	2
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1946	69.6	172.9
1947	51.7	132.6
[illegible]	[illegible]	[illegible]
1950	50.8	79.1
1951	23.5	71.4
1952	24.1	25.5

1953	9.9	30.8
1954	14.3	34.0
1955	8.4	47.7
1956	5.9	34.4
1957	7.1	33.8
1958	9.5	47.8
1959	8.5	47.5
1960	2.5	52.8

6. Environmental sanitation services in this province are provided by 3 fully qualified sanitary engineers, 19 full time sanitary inspectors and one public veterinarian. The 3 sanitary engineers are employed by the Department of Health, while the sanitary inspectors and the veterinarian are employed by the municipal boards of health. The Department of Health provides 50% of the salary and 50% of the travel for 16 Inspectors and the Public Health Veterinarian as assistance to the Boards of Health. The salaries of the 3 Sanitary Engineers are paid by the Department of Health. The annual expenditures on sanitary services by the Department is $67,000.00, while the boards of health spend approximately $50,000.00 from municipal public funds. The Department expenditure is claimed, approximately 85% from National Health Grants. This program of assistance to the Boards has made a system of full time sanitary inspectors possible and is a marked improvement over the former system of part-time inspectors. The sanitarians, new employed, have improved their status by training courses sponsored by the health departments of New Brunswick and Nova Scotia.

1953	9.9	30.8
1954	14.3	34.0
1955	8.4	[illegible]
[illegible]	[illegible]	[illegible]
1957	7.1	33.8
1958	9.5	47.8
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The program must show continued improvement otherwise it tends to become routine and will accomplish little of real worth. The day to day field supervision is by the District Medical Health Officers of the various districts. The Sanitary Engineers provide an advisory and consultation service on all matters related to environmental sanitation in the province.

7. In order to accomplish more with the sanitarians we now have, flexibility as to their work areas would be desirable. The work allowance from county to county is very much out of proportion. There is also a considerable variation in salary and working conditions. In order to alleviate the conditions as outlined, something should be done by the Department of Health to strengthen the sanitation service. We should also consider our investment in time and money expended. Since it may be many years before we initiate a system of health units in this province, sanitarians might be employed to form a section of the Sanitary Engineering Division and be given Civil Service Status. They could They could then be trained according to their abilities and placed in the districts requiring their individual knowledge. They should be placed under the day to day supervision of the District Medical Health Officer. The Sanitary Engineering Division would give general field supervision. If the Department were to take over full financial responsibility for environmental sanitation, it would entail an estimated expenditure in 1963 of $147,000.00. At the present time the Department is providing assistance to the extent of $67,000.00 which would

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Sanitary Engineering Division would give general field
supervision. If the Department were to take over full

it would entail an estimated expenditure in 1953 of
$147,000.00. At the present time the Department is pro-

increase to $70,000.00 by 1963. Then the additional net expenditure required would be $77,000.00 from provincial funds.

SECTION C

MENTAL HEALTH

It is evident to all, that our society and our culture, is burdened with an enormous load of disabilities associated with psychosis and other forms of mental illness. This is becoming an increasingly serious health problem and hitherto, health facilities for mental disease have concentrated on large institutions and scattered diagnostic clinics. Thus far, our methods have not been highly effective in preventing or curing mental illness. It has been a long tradition that mental disabilities came to light only when they were extremely serious and thus, of necessity, because of their seriousness, must be admitted to large and sometimes isolated mental institutions. Recently it has been realized that attempts must be made to find these mental and psychiatric disabilities in the early stages and treat them before they progress and become chronic. This requires some change in the pattern of our facilities with a certain emphasis placed on psychiatric units disseminated throughout the province. It now seems appropriate to describe the existing facilities and suggest in a general way, recommendations designed to provide more effective and improved service for the care, treatment and prevention of all forms of mental illness.

INTRODUCTION

It is evident to all, that our society and our culture, is burdened with an enormous load of [illegible] associated with psychosis and other forms of mental illness. This is becoming an increasingly serious health problem and hitherto, health institutions for mental disease have concentrated on large institutions and academic diagnostic clinics. Thus far, our methods have not been highly effective in preventing or curing mental illness. It has been a long tradition that mental disabilities came to light only when they were extremely serious and thus, of necessity, because of their enormousness, must be admitted to large and elsewhere isolated mental institutions. Recently it has been realized that attempts must be made to find these mental and psychiatric disabilities in the early stages and treat them before they progress and become chronic. This requires some change in the pattern of our facilities with a certain emphasis placed on psychiatric units disseminated throughout the province. It now seems appropriate to describe the existing facilities and suggest in a general way, recommendations designed to provide more effective and [illegible] for all forms of mental illness.

EXISTING FACILITIES

1. Mental Hospitals: There are at present, two mental hospitals, one located in the north of the province and one located in the south of the province. These have a combined rated bed capacity, by national standards, of 1378 beds. There are 1922 beds set up and occupied in these two hospitals. In the year of 1960, these two hospitals provided 684,488 hospital days of care to the mentally ill. This service was provided at an operating cost of $3,220,000.00.

2. Community Services: This service consists of four psychiatric clinics located at four centres throughout the province. Each clinic is serviced by a team consisting of a psychiatrist, clinical psychologists, psychiatric social workers and a clerical staff. These clinics are financed from National Health Grants with some additional financial assistance from provincial funds. The clinics provided a diagnostic and treatment service. A significant part of the work in each clinic is with children in terms of behavior problems and mental retardation. In many cases, the treatment teams in these clinics are not especially trained in this area of work. These four clinics were operated in 1960 at a cost of $138,000.00.

3. Psychiatric Wards in General Hospitals: There are three psychiatric sections in active treatment general hospitals of the province. Two of these sections with a total of 35 beds, are in provincially operated hospitals and one of 30 beds is in the Department of Veterans' Affairs Hospital, owned and operated by the Government of

mental hospitals, one located in the north of the province and one located in the south of the province. These have a combined rated bed capacity, by national standards, of 1,775 beds. There are 1,222 beds set up and occupied in these two hospitals. In the year of 1960, these two hospitals provided 684,488 hospital days of care to the mentally ill. This service was provided at an operating cost of $5,250,000.00.

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Canada, which provides service to entitled veterans resident in the province. The professional service at this hospital is provided by one full time psychiatrist and a half-time psychiatrist, on a salary basis. The para-medical personnel are also on full time salary in this unit. The psychiatric service at the two units in the provincially operated active treatment hospitals, is provided on a fee for service and is the responsibility of the patient concerned.

4. Present Expenditures: The total cost of mental health services in 1960, excluding cost in active treatment general hospitals, was $3,358,000.00.

Analysis of this cost, indicates the following:

Ten per cent was provided from National Health Grants.

Four per cent was paid by municipalities on behalf of patients.

Ten per cent was paid by patients on their own responsibility.

Seventy-six per cent was paid by provincial government funds from consolidated revenue.

In effect, then ninety per cent of this expenditure was paid from public funds.

5. Deficiencies in Present Facilities: It is an accepted fact that there are not enough beds to properly accommodate the present in-patient population of our mental hospitals. This is resulting in marked overcrowding. For example, approximately 2000 in-patients are accommodated in a bed space, rated by national standards, to accommodate approximately 1400 patients. For various reasons incidental to the overcrowding, modern methods of

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treatment may be difficult or impeded. Mental illnesses are commonly expressed in problems of social and personal interaction and therapeutic efforts must utilize this field by guidance, re-training and rehabilitation in the broad sense. In terms of a total treatment program, there is also a deficiency in staffing our mental hospitals and clinics with professional personnel.

The active treatment general hospital psychiatric units referred to above, exist only in three hospital centres in the south of the province. It is therefore obvious that the treatment of certain types of mental illness, in terms of community treatment facilities, is inadequate and consequently facilities in general hospitals should be definitely increased in areas of the province where such facilities do not exist at the present time.

In regard to the community mental health clinics, there are certain areas of the province with a relatively heavy concentration of population which have no clinic facilities within a reasonable distance.

The foregoing remarks concerning deficiencies have been based on the quantative aspects. In terms of the qualitative aspects, it is evident that there is a lack of properly segregated facilities for the efficient care of certain categories of mental illness such as:

(a) Criminally insane

(b) Behavior problems

(c) Mental defectives and mentally ill children

treatment may be difficult or impeded. Mental illnesses are commonly expressed in problems of social and personal interaction and therapeutic efforts must utilize this field by guidance, re-training and rehabilitation in the broad sense. In terms of a total treatment program, there is also a deficiency in staffing our mental hospitals and clinics with professional personnel.

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(a) Criminally insane

(b)

(c)

children

(d) Alcoholics

(e) Drug Addicts

(f) Mental senility of the aged

In general hospital psychiatric units, there is lack of bed space in widely dispersed areas of the province and in such units there is a lack of specially trained nurses, occupational therapists, social workers and psychologists.

In the community mental health services, there are no special facilities for the mentally deficient and distrubed children, there are no day hospitals, no special facilities for dealing with alcoholics and an almost complete lack of any organized forensic service.

The present level of services is sometimes hampered by a real shortage of medical and certain kinds of ancillary staff. As regards medical staff, there is a shortage both in hospital and in community mental health services. This also applies to para-medical staff such as psychologists, social workers, psychiatric nurses and occupational therapists.

As regards psychiatrists, the main difficulties are:

(a) Unattractive and non-competitive remuneration

(b) Lack of prospects for future development and personal advantages

(c) Psychiatry is one of the least attractive specialties.

The foregoing also applies to the shortage of

(d) Alcoholics

(f) Mental sanility of the aged

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In the community mental health services, there are no special facilities for the mentally deficient and disturbed children, there are no day hospitals, no special facilities for dealing with alcoholics and an almost complete lack of any organized forensic service.

The present level of services is sometimes hampered by a real shortage of medical and certain kinds of auxiliary staff. As regards medical staff, there is a shortage both in hospital and in community mental health services. This also applies to para-medical staff such as psychologists, social workers, psychiatric nurses and occupational therapists.

As regards psychiatrists, the main difficulties are:

(a) Unattractive and non-competitive [illegible]

(b) Lack of prospects for future development [illegible]

(c) Psychiatry is one of the least attractive [illegible]

The foregoing also applies to the shortage of

psychiatric nurses.

The difficulty in obtaining occupational therapists is due to the fact that present training is designed chiefly for the physically disabled rather than for the mentally ill, for which a fundamentally different technique is required. As regards social workers and psychologists, the chief cause would appear to be movement of trained personnel. The training program in this field has been rather extensive during the past twelve years but relatively large numbers of these trained personnel have left the province for other areas of Canada and United States, apparently for more attractive remuneration and working conditions.

6. Recommendations for Future Mental Health Services:

The above noted deficiencies point clearly to some of the extensions and improvements required in the field of mental health. It is true that in an area the size of New Brunswick, with only two mental hospitals available, that treatment for many patients is carried out in a place far removed from the patient's home and community. There is therefore the need for a greater number of smaller treatment units scattered throughout the province. It now seems practical to develop in-patient units in association with general hospitals which would operate in close association with mental health clinics throughout the province. Consideration of present needs indicate that at least eight out-patient clinics should be established.

It has been found elsewhere, that day hospital

psychiatric nurses.

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facilities in conjunction with out-patient clinics, give an important and useful service in handling a number of patients who would otherwise require admission to mental hospitals.

There is a great need for Hospital Training Schools for the mentally defective and retarded children as well as out-patient services for such children. A child guidance service for the mentally ill child as well as the child with behavior problems, is both desirable and necessary and a separate service for alcoholics and drug addicts should be instituted.

There should be special services for the long term care of the aged who are mentally ill by virtue of senility and if possible, such care should be given in a special section outside the active treatment mental hospital. These facilities should, as far as possible, simulate the home surroundings of the aged patient. This might require some kind of special housing with daily visiting by professional health personnel such as public health nurses and social workers as well as periodic visits by the patient's own doctor in conjunction with psychiatric consultation.

7. Mental Hospital Bed Requirements:

1. As noted previously, the provision of psychiatric beds in special sections of active treatment general hospitals is now a trend in the treatment of selected cases of mental illness. This trend is felt to be desirable and advantageous to the patient concerned because a more active and intense type of therapy is available in these small sections than that which is feasible or possible in large mental hospitals. These

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sections would provide treatment for the short or moderate term case of mental illness.

If we use the factor of ten per cent of the beds in general hospitals which have a capacity of 100 beds or over as allotted to the treatment of mental illness, it would require that an additional 180 beds be provided as psychiatric beds for the treatment of mental illness in general hospitals. In view of the fact that these beds would be provided as additions to existing general hospitals, the basic cost is estimated at $8000.00 per bed.

The total cost therefore of this basic facility would be :

180 beds X $8000.00 = $1,440,000.00.

2. In view of the fact that there is definite overcrowding in one of our mental hospitals, more beds of this type are required. There are 1922 patients in this type of hospital which has a rated capacity of 1378 beds in the two hospitals. It is therefore estimated that a future requirement would be space for 700 beds.

In the light of past experience in construction costs at Provincial Hospital, Campbellton, this additional bed space can be provided at an average cost of $6,000.00 per bed. This would result in a total construction expenditure of 700 x $6000.00 = $4,200,000.00.

3. Hospital facilities for the mentally deficient and mentally disabled children in the province are not available at this time. Plans are being made for this type of service in the future.

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In the immediate future, an institution of

this type should be provided in the south of the province with a capacity of 240 beds with all related facilities for this type of health care.

Estimated cost of construction would be $11,000.00 per bed with total cost 240 X $11,000.00. = $2,640,000.00.

Following completion of these facilities, an extension of like facilities to the north of the province would be necessary. It is estimated, space for 160 beds would be required in the northern area. The cost of providing such facilities would be as follows: 160 X $11,000.00 = $1,760,000.00.

To complete these facilities in the foreseeable future, an additional institution of this type might be required in the southeastern area of the province at or near Moncton which is the centre of a fairly dense population.

This would be estimated at space for 150 beds constructed at the following cost:

150 X $11,000.00 = $1,650,000.00.

It is to be noted that no estimates relative to the annual cost of operation of these extended services in mental health have been made at this time. The time factor in preparing this submission is such that operational estimates cannot be completed at this time but such estimates will be made available at a later date.

8. Professional Staff in Mental Health Services:

(a) There are 28 physicians engaged in mental health in New Brunswick of which 26 are on full time salary basis, one on half-time salary and one in private

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(e) There are 28 physicians engaged in mental health in New Brunswick of which 26 are on full time salary basis, one on half-time salary and one in private

practice on a fee for service basis. The individual on half-time salary basis engages in private practice of psychiatry on a fee for service basis the remaining half-time.

It is estimated that the province would require a total of 57 physicians working in this type of health care service. Of the 28 presently in the province, slightly less than 50% of these are fully qualified psychiatrists.

(b) There are 15 qualified psychologists on a full time salary basis providing this service in mental health. It is estimated that to provide this service adequately in the future, it would require a total of 20 such qualified personnel.

(c) Psychiatric Social Workers in mental health at thepresent time, number 13. These are all employed on a full time salary basis. To provide adequate service in the future, it is estimated we would require a total of 26 qualified psychiatric social workers.

(d) Registered and graduate nurses on the staff of our mental hospitals is 25% below the accepted standard for such institutions.

Nurses with post-graduate training in psychiatric nursing are well below the desired level in numbers for such specially trained personnel.

9. Conclusion

The estimated increase required in bed facilities set forth avove, if completed by 1956, would result in a total rated bed capacity in that year, of 2873 psychiatric beds. With an estimated population in

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The estimated increase required in bed facilities set forth above, if completed by 1956, would result in a total rated bed capacity in that year, of 2673 psychiatric beds. With an estimated population in

1956 of 650,000 for New Brunswick, this would provide a psychiatric bed ratio of 4.4 per thousand of population. It seems apparent that this would be a desirable ratio for this province.

In conclusion, it is here pointed out that considerable differences of opinion exist as to the desirability of extending and increasing psychiatric units in active treatment general hospitals of the country. The following quotation from Report No. 73 of the World Health Organization is of interest on this subject:

"Naturally these ideas -- and enthusiasm -- are not shared by all and the opposition point of view is summarized best, perhaps, by Report No. 73 of the World Health Organization, "The Community Mental Hospital". In part this report says "The Committee cannot accept as axiomatic ... the view that psychiatric units in general hospitals are the most desirable form of provision for psychiatric care". It is explained that the Committee were of the opinion that the mental hospital "did not do its best job by imitating the general hospitals. Too often, psychiatric wards of general hospitals are forced by the expectation of hospital authorities to conform to a pattern which is harmful to their purpose."

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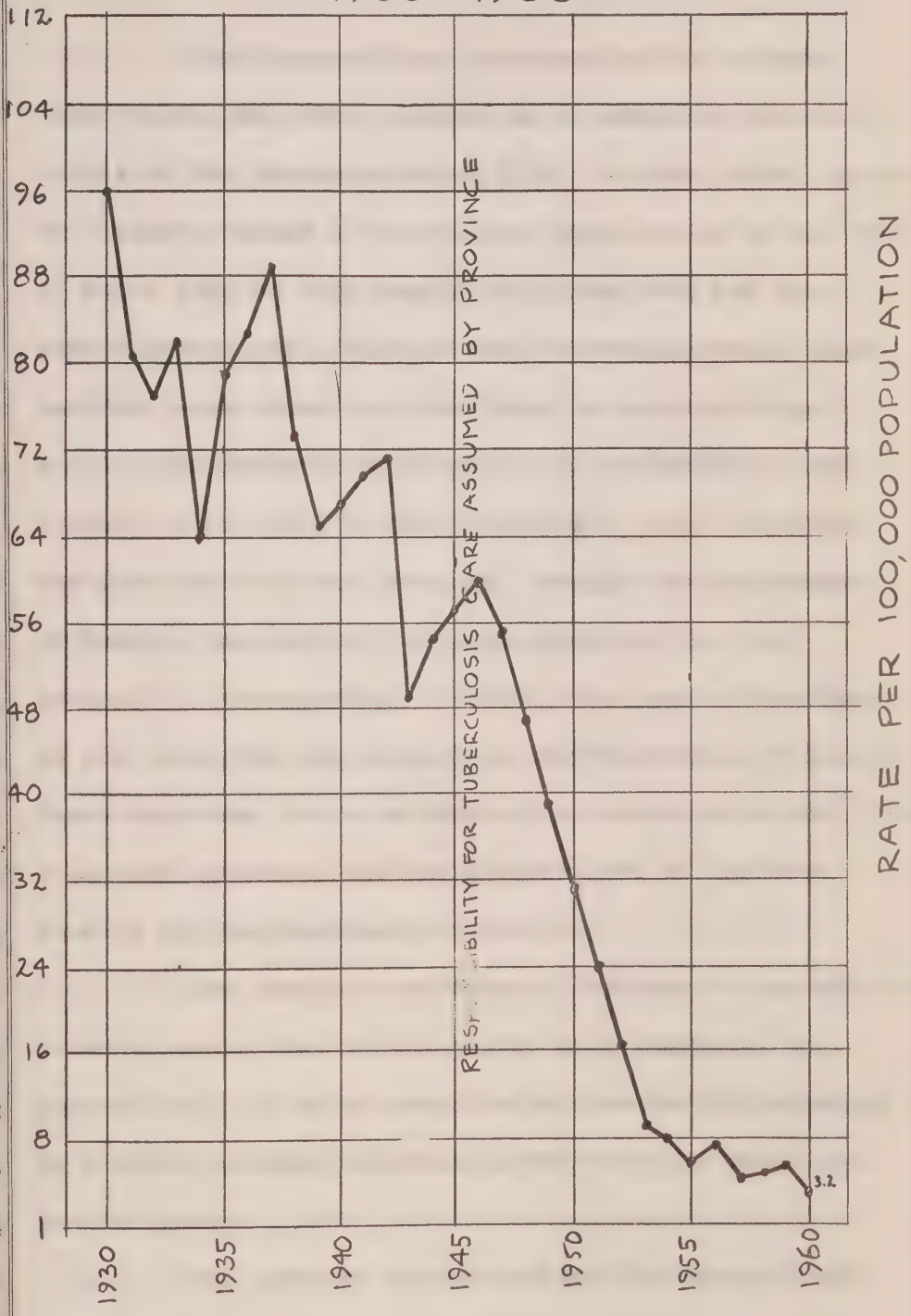
TUBERCULOSIS DEATH RATE
IN NEW BRUNSWICK
1930 - 1960



TUBERCULOSIS DEATH RATE
IN NEW BRUNSWICK
1930 - 1960
DEATHS PER 100,000 POPULATION
1930
1940
1950
1960

SECTION D

TUBERCULOSIS HEALTH SERVICES

The diagnosis and treatment of the disease Tuberculosis has been accepted as a community responsibility in New Brunswick since 1910. At that time a group of citizens formed a Tuberculosos Association in the City of Saint John to help people afflicted with the disease tuberculosis. Through the intervening years, more services were added, and now there is provided diagnostic and treatment services to all residents of the Province at no cost to the individual. Over the years, the Government of the Province, through the Department of Health, has assumed the responsibility for the control of tuberculosis. In 1945, the cost of treatment in the Sanatoria was assumed by the Department of Health. There continues to be assistance to tuberculosis work from voluntary agencies, but the greater part of the work done is by the Department of Health.

The disease tuberculosis, because it has affected so many people, has been accepted as a community responsibility. It is a communicable disease and therefore is a health problem accepted by the official provincial health agency.

The services being provided for Tuberculosis in New Brunswick compare favorably with other provinces of Canada. The Canadian picture is equal, or better, than many other countries.

The assumption of responsibility for the problem of tuberculosis by the Department of Health

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The assumption of responsibility for the problem of tuberculosis by the Department of Health

means that this should probably be continued. A chronic type of disease, requiring long treatment and follow-up, each case requires a great deal of medical care. Similarly, because it is infectious there are case-contacts to follow for some considerable time by clinic observation. This phase of the work also requires medical coverage.

During recent years there has been an increasing shortage of physicians in New Brunswick trained in tuberculosis work both in the treatment and clinical aspects of the disease. Because tuberculosis is a very complex disease and has many aspects with regard to its control, the care and management requires physicians experienced or specially trained. Many phases of the management of the disease involve parts of the other specialist phases of medicine. X-ray interpretation, drug therapy, thoracic surgery, and orthopedic knowledge are requirements as they pertain to this disease. The shortage of these trained physicians is not only confined to this province, but to other parts of the world.

There are several reasons for this shortage of physicians experienced in this disease. One reason is the improvement in the tuberculosis situation which has caused this disease to become one of declining interest for the younger physicians. It is also a chronic disease and therefore has not the same appeal as does the more emergent general medicine.

Despite the marked improvement in the whole tuberculosis situation, there remains a great deal of

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the disease throughout the world. If the progress which has been made is to be maintained, the same methods of dealing with the disease must be continued for years. It is not anticipated that the services now being provided will, in the forseeable future, be discontinued. Therefore, medical man-power becomes a need for many years to come.

In the Province of New Brunswick at the present time, of the four Institutions providing treatment there are 12 Physicians and only 3 are Canadian-born. As other countries improve their medical standards, this source of foreign-born physicians will decrease.

It is not considered likely that the physicians in private practice can or will be able to take over the complete care of the tuberculosis work at least until there is much less disease than exists at the present.

Once embarked upon the care of tuberculosis, it will not be possible for the Department of Health to withdraw now or in the foreseeable future. One of the important parts of this care is the provision of adequately trained medical personnel. It is here emphasized that we must not relax our efforts in the prevention, diagnosis, treatment and rehabilitation of tuberculosis patients until the disease is eradicated from our population. We cannot say or assume that the disease has been eradicated or controlled until such time as there is a complete absence of positive reactors to tuberculin in our population. So long as there remains one positive reactor this individual is or may

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become a potential source of infection to others.

The present status of the disease in New Brunswick shows a very favorable trend from the point of morality statistics where the death rate per 100,000 population has dropped from 98 in 1930, to 3.2 in 1960. When the Department of Health assumed responsibility for all phases of the disease in 1945, the mortality rate was 59, and fifteen years later in 1960, the mortality rate was 3.2. (Refer to enclosed graph). Unfortunately, the morbidity rate is not showing such a favorable trend. In the year of 1960, there was 459 new cases found. This is an increase over the previous year when 407 new cases were found. This, no doubt, is due in part to increased activity and effort on the part of our case finding services.

Health Care for Tuberculosis

This service consisting of prevention, diagnosis, treatment, and rehabilitation was provided in the year of 1960 at a cost of $2,380,000.00. Analysis of this cost indicates that slightly less than 7% was claimed from National Health Grants and slightly over 93% was paid by the provincial government. In other words, 100% of the cost of health care in tuberculosis is paid from public funds.

The cost of prevention and diagnosis in the field services was $94,000.00, while the cost of treatment and rehabilitation $2,286,000.00. The major portion of this cost was for treatment in tuberculosis hospitals.

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by 14 qualified medical doctors working on a full-time salary basis.

The New Brunswick Tuberculosis Association, a voluntary agency, renders valuable assistance in the operation of a mobile chest X-ray unit, and also in the field of rehabilitation of the tuberculosis patient and ex-patient.

There are 710 beds in the rated bed capacity of the four tuberculosis hospitals in the province. The beds occupied average approximately 400 beds. The total hospital days of care given to patients in the year under review was 175,944 days.

It is here noted that arrangements are now being completed for the conversion of 85 beds in the north of the province and 90 beds in the south of the province from tuberculosis service to be utilized as active-treatment beds in general hospital service operating under the New Brunswick Hospital Service Plan. This will leave a net total of 535 beds for the treatment of tuberculosis.

Despite the apparent improvement in the health picture for tuberculosis in the province and the decreasing demand or need for beds in these hospitals, the total cost of the program is showing only a slight decrease as will be noted from the following table of costs.

YEAR	TOTAL COST OF HEALTH CARE FOR TUBERCULOSIS
1955	$2,344,000.00
1956	2,276,000.00

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1955	$2,344,000.00

1957	2,421,000.00
1958	2,557,000.00
1959	2,666,000.00
1960	2,298,000.00
1961	2,380,000.00
1962 Estimated Budget	2,013,000.00

From the above table, it would appear that the total cost of this segment of health care will show a small decrease in total cost during the next ten years.

Case Finding Services

As previously mentioned, the case-finding services resulted in 459 new cases of tuberculosis entering the various sanatoria for treatment. This is an increase over the previous year when 407 new cases were admitted. Various factors entered into this increase. The main one is that a greater effort is being made to bring cases with primary or early infection under treatment so as to prevent breakdown in the future.

Of the 459 new cases admitted to sanatoria, there were 72 who were found to be infectious before entering sanatoria. This does not mean that the remainder were not infectious, but had not been completely tested prior to admission. The group who were infectious would be very strongly infectious and therefore a definite menace to those to whom they were in contact. It is believed that by locating these cases and then isolating them in sanatoria, the best work of the Division is being accomplished. These are the people who are capable of

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causing the cases of the future.

During the year 1960, there were approximately 14,000 people who had a tuberculin test done in survey groups. This does not include the larger number who attended the diagnostic procedure. If the 14,000 people examined, 5.5% were found to be positive. The majority of these people were school children and the rates varied from a high 14% to 1%. The higher figure was found in certain counties where groups were done who were suspected of having a high rate of infection and the survey was done prior to a visit of the Mobile X-ray Van. The majority of this work was done by the District Health Nurses in the various parts of the districts of the province. The importance of the Tuberculin Testing program must not be overlooked. All of the positive people were followed up either through a survey film taken immediately or referred to one of the Diagnostic Clinics for a clinical examination including X-ray. This part of the program found a number of new cases and also placed a number of suspicious people under observation. In certain of the districts, examination of the persons found to have a positive tuberculin resulted in other members of the family being done in an effort to find the source of the infection. In addition to the location of positive reactors, this whole part of the program is of tremendous educational value.

The X-ray part of the case-finding service is carried out mainly through the hospital admission chest X-ray examination, the mass X-ray surveys and the tuberculosis diagnostic clinics.

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The X-ray part of the case-finding service

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1. General Hospital Admission Chest X-ray Examination.

There are thirteen General Hospitals and one Clinic in the Province where chest X-ray equipment has been installed for the purpose of examining all the patients admitted. In 1960, there were 18,484 persons examined by this method. The results of the chest X-rays indicated that some 132 persons were found to have tuberculous disease in an active or questionable form. Some of this group were considered to be new cases and the majority of them went on immediately to sanatorium for treatment while some of the others were kept under the observation of the Diagnostic Clinic or their own physician.

With the advent of the Hospital Insurance whereby all patients admitted to hospital receive in-patient examination at no extra charge it seems that there has been a decrease in the number of admission films being taken. Several of the hospitals are neglecting this very valuable case-finding method, and one of the reasons given is that most of the patients have a large chest X-ray film taken while they are in hospital and the miniature film of the admission program is not now essential. This is not a good reason and simply means the hospitals are not providing the service for which these X-ray units were placed. Efforts are being made to improve this phase of the service.

Besides detecting tuberculosis, this hospital admission X-ray examination is capable of detecting any other chest conditions. During 1960, there were 661

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With the advent of the Hospital Insurance whereby all patients admitted to hospital receive in-patient examination at no extra charge it seems that there has been a decrease in the number of admission films being taken. Several of the hospitals are neglecting this very valuable case-finding method, and one of the reasons given is that most of the patients have a large chest X-ray film taken while they are in hospital and the miniature film of the admission program is not now essential. This is not a good reason and simply means the hospitals are not providing the service for which these X-ray units were placed. Efforts are being made to improve this phase of the service.

Besides detecting tuberculosis, this hospital admission X-ray examination is capable of detecting any other chest conditions. During 1960, there were 661

found to have abnormal chest conditions, probably not tuberculosis. This is a very valuable screening process to determine chest disease and it, of course, follows that the more people examined result in a much improved disease detecting service.

2. Mass Chest X-Ray Surveys

There was a slight decrease in the number of persons examined by the Mobile Chest X-Ray Van throughout the Province during the year 1960. The total number examined was 53,840 in 1960 compared with 59,008 in 1959. The main reason for the decrease was that the van was directed to certain parts of the Province where the need was considered to be greatest.

Thirteen of the fifteen counties had some work done by the van during the year. The bulk of the work was done in the counties of Gloucester and York. Almost two-thirds of the total number of people examined were in these two counties. This was a concentrated effort, particularly in York, where a city wide survey was done on a house-to-house basis in the city of Fredericton. In Gloucester County, several of the larger centres of the county were done in a similar manner.

There were 85 persons examined by the survey van who were found to have tuberculosis considered active. The majority of these people were immediately admitted to sanatorium for treatment, some of the others are under observation to determine the present status. This number is higher than in 1959 (78). It is quite significant that more than half of the total were located in one county though, of course, a concentrated

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survey program was carried out there.

Other findings in the survey work were quite comparable to the previous year.

Because of the fact that the survey van has been operating through the province for the past 13 years, there is now a large percentage who have had previous films. When some abnormality is noted, a search is made in the Mobile Film Library for a comparison film and the new film is evaluated on the basis of previous appearance. This method of evaluating the survey films prevents needless reporting and allows for a better report to be given. It is also of interest to note that the film library is constantly requested to provide comparison films for hospitals, clinics and other case-finding services.

The Mobile X-ray Van operates as a joint effort of the New Brunswick Tuberculosis Association and the New Brunswick Department of Health. The Department provided the X-ray equipment and the staff to operate and develop and report on the films. The Association provided the van and has a survey organizer who arranges the survey schedule. Interest continues to be high upon the part of people in the communities for the work being done by the van and the response remains quite constant.

The equipment operated during the whole year. There were no major mechanical problems. The work which is being done is in a large part due to the excellent staff which operates the van under often difficult situations and adverse weather conditions.

The table which follows shows the summary of the X-ray survey work done in the province during the year.

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The table which follows shows the summary of the X-ray survey work done in the province during the year

Thirteen counties were visited and the other two will have work done in the year 1961.

SUMMARY OF X-RAY SURVEY REPORTS - 1960

COUNTY	Total No. Films Taken	Tuberculosis TBC. Active	Doubtful	Inactive	Suspects	Non-Toc. No. Diag. Etc.	Negatives
ALBERT COUNTY	1,426	5	-	6	2	9	1,404
CHARLOTTE COUNTY	1,871	-	-	4	-	22	1,845
GLOUCESTER COUNTY	15,365	50	6	73	58	74	15,104
KENT COUNTY	891	1	1	5	7	10	867
KINGS COUNTY	114	-	-	1	-	-	113
NORTHUMBERLAND COUNTY	3,287	6	1	16	9	5	3,250
QUEENS COUNTY	1,579	1	-	6	10	3	1,559
RESTIGOUCHE COUNTY	3,630	5	-	9	7	5	3,604
ST. JOHN COUNTY	2,847*	1	-	8	1	9	1,823
SUNBURY COUNTY	95	-	-	2	2	-	91
VICTORIA COUNTY	303	1	-	3	2	4	293
WESTMORLAND COUNTY	5,007	-	1	18	4	16	4,970
YORK COUNTY	18,423	15	3	91	25	80	18,209
TOTALS:	53,840	85	12	242	127	237	53,137

*(Includes 76 Spoiled Films)

	Total No.	Tuberculosis			
		Suc. active	Doubtful	Inactive	
[illegible] County					
[illegible]					
				75	52	72
				5	7	10
	6					
	1					
LAFAYETTE COUNTY	2					
				9	1	3	[illegible]
				2	2	—	[illegible]
[illegible]				3	2	[illegible]	[illegible]
				14	—	[illegible]	[illegible]
			2	16	12	[illegible]	[illegible]
				64	[illegible]	[illegible]	[illegible]

Tuberculosis Diagnostic Clinics

The eleven Tuberculosis Diagnostic Clinics do the work which is the most valuable to the case-finding program. These clinics provide a diagnostic service to patients referred by their own physicians and also examine positive tuberculin reactors from surveys and chest X-ray survey rechecks as well as former patients and contacts.

There were 16,933 people examined at the clinics during the year. This is only slightly lower than the previous year when 17,136 were examined. There were 284 cases of active tuberculosis diagnosed and 123 classed as doubtful activity requiring further investigation. Also there were 3,384 people with inactive disease who obviously attended the clinics to be under observation.

During 1960, an improvement was made in the reporting system of the clinics, to the Division of Tuberculosis Control. A new form was drawn up and all cases diagnosed at each clinic as Active or Inactive Tuberculosis are reported by name so that a more complete check is made. In this manner, it can be determined through the Case Registry if these are new cases and then they can be followed-up as to the need for treatment. There is an improvement in reporting and records are kept to correspond with the case registry. This new system enables the Division to keep a check on the occasional recalcitrant patient and take action if necessary.

The clinics are under the individual direction of a physician, either a District Medical Health Officer, a Consultant of the Department or a member of the

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The clinics are under the individual direction of a physician, either a District Medical Health Officer, a Consultant of the Department or a member of the

sanatorium medical staff. Assistance at several of the clinics is provided by the New Brunswick Tuberculosis Association which provides some of the costs of the films. There are several extra clinics held during the summer months in localities distant from the regular operating clinics. These clinics are often held after a visit of the Mobile X-ray Van to the area.

The table which follows shows the result of the clinic work done for the year 1960.

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clinics is [illegible]

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[illegible] These [illegible]

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The table which follows shows the result of

the clinic work done for the year 1950.

TABLE NO. 2

SUMMARY OF TUBERCULOSIS DIAGNOSTIC CLINICS----1960

Name of Clinic	Total Visits to Clinic	Active	Tuberculosis Doubtful Act.	Inactive	Suspicious	Non-Tbc Chest Conditions
CAMPBELLTON TB. CLINIC Board of Health Office Campbellton, N. B. Dr. E. Duguay	520	5	3	98	4	11
CARLETON CO. CLINIC Board of Health Office Woodstock, N. B. Dr. J. R. Allanach, D.M.H.O.	257	3	3	54	-	66
CHARLOTTE CO. CLINIC Charlotte Co. Hospital St. Stephen, N. B. Dr. C. H. Oake, D.M.H.O.	281	8	4	50	22	50
FREDERICTON TB. CLINIC Victoria Public Hospital Fredericton, N. B. Dr. J. R. Allanach, D.M.H.O.	870	18	4	219	-	238
GLOUCESTER CO. CLINIC Hotel Dieu, Tracadie, N. B. Dr. E. Duguay	806	53	7	209	20	31
MONCTON GYRO CLINIC 428 Collishaw Street Moncton, N. B. Dr. G. H. Blennerhassett	7,067	80	62	1,181	135	968
NORTHUMBERLAND CO. CLINIC Municipal Home Chatham, N. B. Dr. R. D. Landry, D.M.H.O.	752	7	8	110	15	14
NOTRE DAME DE LOURDES SANATORIUM CLINIC Notre Dame de Lourdes San. Vallee Lourdes, N. B. Dr. E. Duguay	1,668	63	22	407	67	92
RESTIGOUCHE CO. CLINIC Hotel Dieu Hospital Dalhousie, N. B. Dr. E. Duguay	252	1	2	68	-	12
SAINT JOHN TB. CLINIC 260 Germain Street Saint John, N. B. Medical Director	2,993	22	1	791	1,046	571
ST. JOSEPH SAN. CLINIC St. Joseph Sanatorium St. Basile, N. B. Dr. G. E. Gauvin	1,467	24	7	197	11	29
TOTALS	16,933	284	123	3,384	1,320	2,082

TABLE NO. 2

	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Board of Health Office Carmichael, W. A.	270	3	3	3	6	14
CAMLOOPS CO. CLINIC Board of Health Office Woodstock, W. S. Dr. W. E. Allanson, M.L.A.C.	277	3	13	34	–	90
CHAMBO CO. CLINIC Charlotte Co. Hospital St. Stephen, N. B. Dr. C. H. Cates, D.C.H.O.	341	7	4	50	27	46
FREDERICTON TB. CLINIC Victoria Public Hospital Dr. W. R. Allanson, C.M.O.	840	17	4	170	–	24
GLOUCESTER CO. CLINIC Hotel Dieu, Tracadie, N. B.	906	33	7	207	20	32
MONTREAL GYRO CLINIC 428 Guilfoyle Street Montreal, P. Q. Dr. G. H. Mavrogordato	1,567	80	62	1,421	115	[illegible]
NORTHUMBERLAND CO. CLINIC Municipal Home Cobourg, N. S. Dr. J. D. Landry, D.C.H.O.	352	7	8	110	15	14
NOTRE DAME DE LOURDES [illegible] Notre Dame de Lourdes Sen. Vallee Lourdes, N. S.	1,603	69	22	[illegible]	17	–
SASKATCHEWAN CO. CLINIC Hotel Dieu Hospital Dr. E. Quesnel	252	1	2	34	–	12
SAINT JOHN CO. CLINIC [illegible] Medical Director	1,283	22	1	171	1,340	[illegible]
ST. JOHN TB. CLINIC St. [illegible], N. B.	1,497	24	7	197	11	20
TOTALS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

One other phase of case-finding is the examination of chest X-ray films taken at several of the smaller general hospitals. At the Division of Tuberculosis Control, films are sent in from 5 small hospitals for interpretation because there is suspicion of chest disease and tuberculosis is considered to be suspected. During 1960, there were 527 films referred and reported upon to the Hospital and the physician of the patient. Most of these films are taken through an arrangement made by the Tuberculosis Association and the general hospital whereby the cost of the film is provided by the Association. This service results in the finding of cases of tuberculosis as well as other diseases of the chest.

Treatment

The treatment of tuberculosis is provided at the four sanatoria operated by the Department of Health. Also, of course, some patients with mental disease are treated in the Department Mental Hospitals, chiefly at Lancaster. The number of beds available are about 740, but about 100 of these are not in use and not directly covered by staff. There was at no time during the year any appreciable waiting period for adult patients requiring beds; at certain times, mainly in the winter months, some children, not urgent cases, have had to wait short periods for a bed.

The four institutions continued to provide treatment upon the basis of the facilities available as in previous years. Children are allocated to St. Joseph's Sanatorium, St. Basile; Jordon Memorial Sanatorium and

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Saint John Tuberculosis Hospital. The chest surgery is done at Saint John and cases considered suitable are transferred during the year from the other institutions. The cases of bone tuberculosis are referred to Jordon Memorial Sanatorium and medical treatment is provided there with any necessary surgical procedures being done at a Moncton general hospital by the Orthopedic Consultant.

The treatment services of the Department of Health continued to provide care for the Tuberculous Veterans, acting for the Department of Veteran's Affairs. Also under a mutual arrangement, the tuberculous patients from the Province of Prince Edward Island who require chest surgery are transferred to Saint John and their operations performed there.

The province of New Brunswick participated in Canada's acceptance of tuberculous refugees from Europe. This group of people has been prevented from entering the country of their choice because of the person or a member of the family having been diagnosed as having tuberculosis. Under arrangement with the Federal Government, the province agreed to accept and provide treatment for a number of these people. In December 1959, there were 15 who were admitted, and 5 in July 1960, and another 5 in February 1961. All of these patients came to Saint John Hospital, mainly because their families could be cared for by the Immigration Department there. Fortunately, many of those coming had received some treatment and only required a short period of hospitalization. Some required more extensive treatment but by the end of 1960, only two of the first group were under treatment and their recovery enabling them to

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be discharged to normal occupation, was anticipated within a short time.

The table which follows provides some of the general treatment statistics for the year 1960, compared with previous year, 1959.

TABLE NO. 3

	1960	1959
Patients in sanatoria as to December 31st	458	464
Number of patients discharged from sanatoria	1,143	1,295
Number of patients admitted to sanatoria	1,337	1,158
Number admitted found to be tuberculous	988	1,024
Number admitted for first time	459	407
Re-admissions:-		
Reactivations	123	108
Transfers, rechecks, etc	438	527

The information in this table shows that there was a marked increase in the number of patients admitted for the first time, i.e. new admissions. This increase of 11% is significant and has been discussed already in this report. The number of patients admitted to sanatoria was not down much but the total number who were found to have tuberculosis was less.

Deaths from tuberculosis in 1960 numbered 20 and this gave a death rate of 3.2. This is a very

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The table which follows provides some of the general treatment statistics for the year 1960, compared

TABLE NO. 3

as to December 31st.....458	464
Number of patients	
discharged from sanatoria.....1,143	1,205
admitted to sanatoria.....1,537	1,198
found to be tuberculous.....988	1,004
for first time.....459	437
Re-admissions:-	
Reactivations.....123	108
Transfers, recheckes, etc.....438	527

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Deaths from tuberculosis in 1960 numbered 20 and this gave a death rate of 3.2. This is a very

marked drop from the previous year when there were 44 deaths and a rate of 7.4 per 100,000 population.

The Tuberculosis Case Registry for the province is maintained at the Division of Tuberculosis Control. Most of the statistics of this report are provided by this register. The important use of the listings, are, of course, to follow-up cases and contacts and co-relate these with the clinic activities. As of December 31st, 1960, there were 7,625 persons listed as having been diagnosed or observed for the disease tuberculosis. This is the total which have been listed in the province since the registry was started in 1950. Of the number of persons in the registry, 458 were in the sanatoria, 395 were at home receiving drug treatment, and the remainder were considered to be inactive and well.

The Department of Health continues to provide B.C.G. vaccine to residents of the province on a selected basis. There were 194 who received this inoculation. Many of this group were young adults, mainly student nurses, while the remainder were children from homes where tuberculosis is known to be present.

The Rehabilitation Services provided to the tuberculous patients continues to be a valuable phase of treatment. At each of the sanatoria there is a staff available to provide the patients with the help they require. Under the leadership of the Director of Rehabilitation and a Supervisor, whose services are provided by the New Brunswick Tuberculosis Association, the program is carried out.

The report of the Director follows:

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Rehabilitation

As in previous years, for the purpose of reporting rehabilitation statistics, children of pre-school age and patients in hospital for less than thirty days are excluded. During 1959, the total number of patients in hospital was 1,267, while during 1960, this figure dropped to 1,226, a decrease of only 3.2%. However, there was a very marked increase in the number of admissions of children and adolescents; the 1959 figure of 102 having jumped to 157 in 1960. With the young people already in hospital at the close of the previous year, this increase in admissions created a small problem in providing classroom space. However, this was solved and during the year there was a total of 185 children attending school in their appropriate grades. In addition, Kindergarten classes have been held for the five-year-olds at Saint John Tuberculosis Hospital, Jordan Memorial Sanatorium and St. Joseph's Sanatorium, with a total attendance of 28.

Adult activities in hospital parallel very closely those of the previous year, while 51 teenagers were enrolled for correspondence courses with the New Brunswick Department of Education Correspondence School, and 4 other patients were taking courses from University of British Columbia, three from DVA and two from Nova Scotia Tech. The number of women in the four hospitals, who followed the home-markers' course during the fall and winter months totalled 228.

At Saint John Tuberculosis Hospital, two

reporting rehabilitation assistance. Children of pre-school age and patients in hospital for less than thirty days are excluded. During 1953, the total number of patients in hospital was 1,257, while during 1950, this figure dropped to 1,226, a decrease of only 3.4%. However, there was a very marked increase in the number of admissions of children and adolescents; the boys from 1 to 10 having jumped to 147 in 1950. With the young people already in hospital at the close of the previous year, this increase in admissions created a small problem in providing classroom space. However, this was solved and during the year there was a total of 189 children attending school in their appropriate grades. In addition Kindergarten classes have been held for the five-year-olds at Saint John Tuberculosis Hospital, Jordan River Sanatorium and St. Joseph's Sanatorium, with a total attendance of 54.

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At Saint John Tuberculosis Hospital, two

groups of European Refugees were under treatment during the year; the first group numbering 15 and the second group 5. With the exception of two or three, none of these patients had any knowledge of English and a considerable amount of time was spent by the rehabilitation staff in attempting to teach this, in some cases with outstanding success. One particularly interesting case is that of a third year medical student who, during his year in hospital, learned English and for whom efforts are now being made for him to continue his medical studies here in Canada. In the meantime, the Saint John Tuberculosis Association has supplied him with medical text books to study during his convalesence.

Post-discharge training again is an important part of the whole rehabilitation program, and this year there have been 68 patients enrolled in 18 different courses. Of these trainees, one of the most praiseworthy is a girl now at Teachers College. As a preschool age child, she was admitted to the Saint John Tuberculosis Hospital, and as a patient had reached grade 3 when transferred to the Moncton Tuberculosis Hospital for surgery of right hip. For the next six years, she remained there on treatment, was an active member of the 4H Club, the Brownies and the Girl Guides successively, and, except that she did lose one year while undergoing further surgery, made excellent progress with her school work.

Discharged as a grade 9 student, she was encouraged to enter high school and was visited regularly at her hime by Miss MacLellan. Last year she matriculate

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and was approved by the provincial Schedule R selection committee for training at Teachers College. Despite more than ten years in hospital and the residual disability of a fused hip and a built up shoe, this girl is now well equipped to lead a good, satisfying life and also to make a real contribution to society.

Statistical reports of both in-hospital and post-discharge training are attached.

IN-HOSPITAL ACTIVITIES - January 1st to December 31st, 1960

Total Number of Patients in hospital during the year.....1,226

Patients engaged in Studies:-

Children attending school.....185
Adults - Academic.....274
Adults - Vocational.....238
Adults - Commercial.....55
Adults - Handicrafts.....478
Adults - Woodworking and Drafting.....27
Adults - Watch Repair.....15
Adults - Radio and T.V.....3
Adults - Art.....9
Enrolled for Home Economics Course.....228
Enrolled for Correspondence Course.....51
Part-time employment.....17

[illegible] for training at Terebona College. Despite more than ten years in hospital and the resultant disability of a fused hip and a malfunctioning shoe, this girl is now well equipped to lead a good, satisfying life and also [illegible]

Statistical reports of both in-patient and post-discharge training are attached.

IN-HOSPITAL ACTIVITIES - January 1st to December 31st, 19[illegible]

Total Number of Patients in hospital during the year.....

Patients engaged in training -

Children attending school.....

Adults - Handicrafts.....

Adults - Radio and T.V. .....

Enrolled for home Correspondence Course.....

Part-time employment.....

POST DISCHARGE TRAINING - January 1st to December 1st, 1960

	Courses Completed	Courses Current
Auto Body & Fender Repair	-	3
Barbering	6	3
Beauty Culture	1	3
Cabinet Making	1	-
Carpentry	1	-
Clerical & Bookkeeping	7	7
Dressmaking	1	1
Electricity	1	-
Plumbing	-	2
Practical Nursing	2	1
Shoe Repair	-	1
Shop Instructor	-	1
Stenography	6	10
Teacher Training	-	2
University Training -Commerce	-	1
Watch Repair	-	1
Welding	-	1
X-Ray Technology	1	1
Totals:	27	38

Summary

The work carried out against Tuberculosis in the province is the result of the effort of many persons and groups. The District Medical Health Officers with their Nursing service give a considerable portion of their

POST DISCHARGE TRAINING - January 1st to December 1st, 1960

	Completed	Current
Auto Body & Fender Repair	-	3
Barbering	6	3
[illegible]		
Cabinet Making	1	-
[illegible]		
[illegible]		
Dressmaking	1	1
[illegible]		
[illegible]		
[illegible]		
Shoe Repair	-	1
Shop Instructor	.	1
Stenography	6	10
Teacher Training	-	2
University Training -Commerce	-	1
[illegible]		
Welding	-	1
X-Ray Technology	1	1
Totals:	27	32

The work carried out against Tuberculosis in the province is the result of the effort of many persons and groups. The District Medical Health Officers with their Nursing service give a considerable portion of their

time to the tuberculosis work in their counties. The voluntary organization, the New Brunswick Tuberculosis Association through their staff and voluntary members contribute much in the field of education and chest survey work. Other government departments in the province provide assistance and also the Government of Canada, particularly through Federal Health Grants, makes possible many of the projects.

It is obvious from the facts and figures which are presented annually in this province and elsewhere in Canada, that Tuberculosis remains as a powerful disease. The past 10 years have produced a great momentum toward eradication of the disease. However, the case-finding program and the educational phases of the disease, among the people, must be continued if the improvement which is known to be possible is to result.

SECTION E

ACTIVE TREATMENT GENERAL HOSPITAL SERVICES

1 Effective July 1, 1959, these services were made available to all residents of New Brunswick under a Federal-Provincial sharing principle. The Federal contribution was provided by the Hospital Insurance and Diagnostic Services Act and the Regulations. This contribution was based on the standard ward net operating cost and excluded the provincial cost of administration. The Federal contribution was computed by means of a formula which gave as assistance to the province 25% of the national average per capita cost of these services plus

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SECTION E

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25% of the provincial per capita cost based on the so-called net shareable costs.

2. The Province provided its share of the costs under the Hospital Care Insurance Act and the Regulations. Financing the provincial share was by a registration and premium method. The premiums were $50.40 annually for each family and $25.20 annually for each single person past the nineteenth birthday. Despite the compulsory aspects of this Plan, approximately 85% of the population was the highest figure reached in registration and payment of premiums was considerably below this figure. Effective January 1, 1961, new provincial legislation known as the Hospital Services Act came into effect, revising the Plan. This revision resulted in the administration which was previously under a Commission being brought into the Department of Health as a Division of Hospital Services with a Director responsible through the Chief Medical Officer to the Minister of Health. The premium method of financing was abolished and the costs are now provided from consolidated revenue of the Province. This then resulted in all residents of the Province becoming entitled persons, with the exception of those who are covered for these services by other Acts of Federal or Provincial jurisdiction.

3. In the year previous to the operation of the Hospital Service Plan, New Brunswick residents received 1288 hospital days per thousand of population at a hospital operating cost of $11,700,000.00, while in the year of 1960, the New Brunswick residents, under the Plan received 1776 hospital days per thousand population at

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called net chargeable costs.

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an operating cost of $18,320,000.00. From these figures, it is to be noted that the increase in volume of care under the Plan was 36%, while the increase in operating cost under the Plan was 56% over the period of the two years under review. In addition, the hospital facilities provided out-patient insured services to the extent of $308,600.00 to residents of New Brunswick. The hospital services now being provided and received by the people of New Brunswick compares very favourably with the national average and indeed exceeds that provided by certain other provinces in Canada.

4. The active treatment general hospitals in New Brunswick in 1949 contained a rated capacity of 1893 beds. In the same year, there were 2326 beds set up and operating. In the year of 1958 (the twelve month period previous to the Hospital Service Plan) there was a rated capacity of 2790 beds. At the end of 1960, there was a rated capacity of 3094 beds. On this same date, there were 3275 beds set up and operating. There are no convalescent hospitals operating as such in the Province at the present time, but the need for such facilities is now becoming evident. There are no chronic hospitals operating with the exception of those provided for the treatment of mental disease and tuberculosis.

5. The facilities for diagnostic services in-patient are all provided under the Hospital Service Plan. Diagnostic services out-patient are provided in laboratory under the plan with a moderate number of tests excluded. Consideration is now being given to the extension of laboratory entitled services which will include the

port

It is to be noted that the increase in volume of care under the Plan was 46%, while the increase in operating cost under the Plan was 70% over the period of the two years under review. In addition, the hospital [illegible] provided out-patient insured services to the extent of $308,000.00 to residents of New Brunswick. The hospital services now being provided and received by the people of New Brunswick compares very favourably with national average and indeed exceeds what provides in certain other provinces in Canada.

4. The active treatment general hospital in New Brunswick in 1949 contained a rated capacity of [illegible] beds. In the same year, there were 2920 beds set up and operating. In the year of 1952 (the last [illegible] period previous to the Hospital Services [illegible] a rated capacity of 2750 beds. At the end of 1955, [illegible] was a rated capacity of 2044 beds. On this same date there were 3275 beds set up and operating. There are no convalescent hospitals operating as such in the Province at the present time, but the need for such facilities is now becoming evident. There are no [illegible] hospitals operating with the exception of those [illegible] for the treatment of mental disease and tuberculosis.

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major portion of the remaining uninsured tests. Extension of out-patient diagnostic service in radiology, cardiology and basal metabolism is also planned. Out-patient services to include minor surgical procedures may also be included. The following are out-patient entitled services under the Plan:-

(i) laboratory procedures as specified from time to time by the Minister together with the necessary interpretations when referred to the provincial laboratory by an approved hospital on behalf of a physician;

(ii) when used in an approved hospital for diagnosis and treatment of an injury received as a result of an accident and for the necessary follow-up care of such injury:-

(A) operating room and anaesthetic facilities including the necessary equipment and supplies;

(B) routine surgical supplies;

(C) necessary nursing service;

(D) laboratory, radiological and other diagnostic procedures together with the necessary interpretations;

(E) drugs, biologicals and related preparations as provided in Schedule II to these regulations,

[illegible] or portion of the remaining uninsured tests. Ex-

[illegible]

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(A) operating room and anaesthetic facilities including the necessary equipment and supplies;

(B) routine surgical supplies;

(C) necessary nursing service;

(D) laboratory, radiological and other diagnostic procedures together with the necessary inter-

(E) drugs, biologicals and related preparations as provided in Schedule II to these regulations.

when administered in the hospital;

(F) recovery room when necessary; and

(G) services rendered by persons who receive remuneration therefore from the hospital; and

(iii) any of the services enumerated in (ii) above, provided in conjunction with physiotherapy facilities where available, when used for medical rehabilitation; and

(iv) any of the services enumerated in (ii) above, when provided for such diagnostic and treatment procedures as are authorized by the Minister from time to time.

6. Future Bed Requirements

The construction of new hospitals and the expansion of existing active treatment hospitals is continuing with the aid of Federal-Provincial assistance of $4,000 per bed, this being $2,000 from each source. For the year of 1961, the total grant from both sources will amount to $1,190,000.00. When these grants were established in 1948, the active treatment hospitals were rated at 1893 beds. During the first 10 years of the grants, from 1948 to 1958, the total grant which was expended from both sources was $7,550,000.00 towards the expansion and improvement of hospitals in New Brunswick. During the present 5 year period from 1958 to 1964, it is estimated that the expenditure from these grants will be

administered in the hospital,

(d) services rendered by persons who receive remuneration therefore from the hospital; and

(iii) any of the services enumerated in (ii) above, provided in conjunction with [illegible] facilities available, when used for medical rehabilitation; and

(iv) any of the services enumerated in (ii) above, when provided for such diagnostic and treatment procedures as are authorized by the Minister from time to time.

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approximately $6,000,000.00. Therefore, over a period of 15 years, the total amount of assistance to hospital construction will be approximately $13,000,000.00, half of which is provided by each government. When the present building program is completed, the distribution of active treatment beds and facilities will be more nearly adequate. It is believed that the additional beds proposed or under construction, will nearly meet active treatment hospital requirements. However, a number of present small hospitals are obsolete or inadequate. In some cases, small hospitals are operating in converted homes and these offer an extreme fire hazard. Replacement of these buildings is being considered for the immediate future.

7. As noted previously, bed capacity in active treatment general hospitals of New Brunswick on December 31, 1960, was 3094 beds. New construction now in progress or approved for construction will provide 263 beds. Estimated cost will be 260 X $14,000 = $2,240,000.00. Extensions to existing hospitals and replacement of obsolete structures with larger modern structures will provide 212 beds at an estimated cost of 212 X $11,000 = $2,332,000.00. Conversion of two existing units from tuberculosis hospital service to general hospital service is now being carried out. This will provide 190 active treatment general hospital beds. The cost of conversion is estimated at $300.00 per bed. Estimated 190 X $300.00 = $57,000.00. It is anticipated that the foregoing construction plan will have been completed by December 31, 1965. This would provide a total rated bed capacity

[illegible]

[illegible] 1, 1960, the model addition of hospitals in Ontario construction will be approximately $15,000,000.00, half of which is provided by each Government. When the present building program is completed, the distribution of [illegible] treatment beds and facilities will be more [illegible] adequate. It is believed that the additional beds [illegible] posed or under construction, will nearly meet [illegible] ment hospital requirements. However, a number [illegible] small hospitals are obsolete or inadequate. In some cases, small hospitals are operating in [illegible] and these offer an extreme fire hazard. Replacement of these buildings is being considered for the immediate future.

7. As noted previously, ten [illegible] treatment general hospitals or new [illegible] 31, 1960, was 5094 beds. New construction [illegible] areas or approved for construction will provide [illegible] Estimated cost will be 500 X $14,000 = $[illegible]. Extensions to existing hospitals and replacement of [illegible] structures with larger modern structures will provide 212 beds at an estimated cost of 212 X $[illegible] = $2,332,000.00. Conversion of two existing units [illegible] tuberculosis hospital service to general hospital service is now being carried out. This will provide 150 [illegible] treatment general hospital beds. The cost of conversion is estimated at $300.00 per bed. Estimated 150 X $300.00 = $57,000.00. It is anticipated that the foregoing construction plan will have been completed by December 31, 1965. This would provide a total of bed [illegible]

of 3759 beds by the end of 1965. Estimating the population of New Brunswick in 1965 to be 660,000, this would provide an active treatment general hospital bed ratio of approximately 5.7 beds per thousand of population. With hospitals operating at a 90% occupancy rate, this would provide 1870 hospital days per thousand of population and this is considered entirely an adequate volume for this type of hospital service.

8. There is now an apparent need for a type of hospital facility to provide hospital services for the convalescent and chronic type of patients. It is felt this type of institution can be constructed and operated at a lower cost than the intensely active type of institution known as the active treatment general hospital. It is estimated that to provide this level of hospital services in New Brunswick, it would require 990 beds of this type by 1965. This estimate is based on 1.5 beds per thousand of population by 1965. Operating at 90% occupancy, this number of beds would provide approximately 500 hospital days of this type of care per thousand of population. To construct these facilities, it is estimated the average cost per bed will be $6000.00. Total cost then would be 990 X $6000.00 = $5,940,000.00.

9. The provisions of Homes for the Aged and Nursing Homes are not considered a health function in this province, but have been placed as a responsibility of the Department of Welfare. The Auxiliary Homes Act passed at the last session of legislature, provides for the establishment of such homes for persons who, through the ravages of age or disease, require custodial and

of 3750 beds by the end of 1965. Estimating the population of New Brunswick in 1965 to be 6[illegible],000, this would

of approximately 5.7 beds per thousand of population

With hospitals operating at a 90% occupancy rate, this would provide 1870 hospital days per thousand of population and this is considered entirely an adequate volume for this type of hospital service.

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personal care but this care is not such as to require active treatment hospital services. Under this new Act, the Province may provide assistance for construction of such homes at the rate of $2,000.00 per bed or 50% of the capital costs including equipment, shichever is lesser. At the present time, there are 999 beds in homes for the aged and 317 beds in nursing homes. Both types of homes are approved under regulations by the Department of Welfare. Future needs for this type of facility is estimated at 2.5 beds per thousand for the aged or an additional 650 beds by 1965 at an estimated cost of $4,000.00 per bed. Estimated 650 X $4,000.00 = $2,600,000.00. Bed requirements in nursing homes are estimated at one bed per thousand population or an additional 343 beds by 1965. The estimated cost of construction and equipment here again is $4,000.00 per bed or a total of 343 X $4,000.00 = $1,374,000.00. The cost of operation of such facilities receives substantial assistance on a per patient per diem basis through the Department of Welfare by virtue of the Social Assistance Act. It is here reiterated that capital and operating costs in these types of institutions are not considered a health function in this Province but have been fixed as a responsibility of the Department of Welfare from where substantial assista is provided.

10. The provision of estimates as to annual operating costs of the additional facilities recommended in the active convalescent and chronic field of hospital facilities have not been made because of the time factor involved in preparing this submission. Such estimates

[illegible] to provide active treatment hospital services. Under this [illegible] such homes at the rate of $2,000.00 per bed or 50% of the capital costs including equipment, obtainable on lease. At the present time, there are 450 beds [illegible] for the aged and 317 beds in nursing homes. Much [illegible] of homes are approved under regulations by the Department of Welfare. Future needs for this type [illegible] estimated at 2.5 beds per thousand for the aged [illegible] additional 650 beds by 1965 at an estimated [illegible] 000.00 per bed. Estimated 650 X $4,000.00 = $2,[illegible] 00. Bed requirements in nursing homes are estimated [illegible] one bed per thousand population or an additional [illegible] by 1965. The estimated cost of construction and [illegible] ment here again is $4,000.00 per bed or [illegible] X $4,000.00 = $1,374,000.00. The cost of operation [illegible] such facilities receives substantial assistance on a [illegible] patient per diem basis through the Department of Welfare [illegible]

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10. The provision of estimates to [illegible] existing costs of the additions. Facilities [illegible] in the active convalescent and chronic [illegible] facilities have not been made because of the time factor

will be made available at a later date. Annual operating costs per bed, related to present facilities may be of interest at this time. In 1960, average operating costs per bed were as follows:

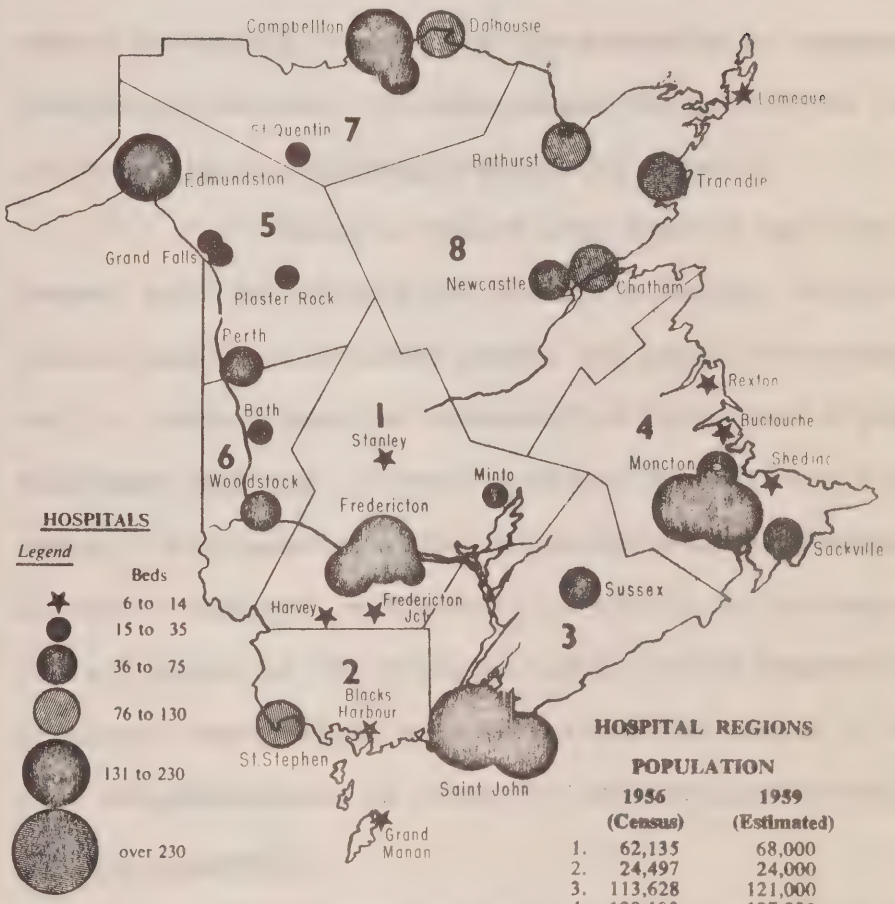
Average operating cost per rated bed was $5,946.00

Average operating cost per bed set up was $5,594.00

In reference to distribution of active treatment general hospital facilities in New Brunswick on January 1, 1960, please refer to the enclosed graph map of the Province.

NEW BRUNSWICK

ACTIVE TREATMENT HOSPITALS



HOSPITAL REGIONS

POPULATION

	1956 (Census)	1959 (Estimated)
1.	62,135	68,000
2.	24,497	24,000
3.	113,628	121,000
4.	120,123	127,000
5.	56,008	59,000
6.	27,319	28,000
7.	39,720	43,000
8.	110,677	120,000
	554,107	590,000

SECTION F

CHILD AND MATERNAL HEALTH

Improvement in the field of Maternal and Child Health at this stage in New Brunswick will, it seems, inevitably depend upon the extension of services provided or secured. To what extent the one or the other is advisable is obviously a matter of opinion.

In trying to report even briefly upon the present position of Maternal and Child Health, outline present and foresee future needs, and still more consider how far these should be "screened" or "provided" a great deal more time and information should be available to the writer. Furthermore, since it is difficult to foresee whether a complete or limited plan should be envisaged for all people of the Province, or a limited extension of present services to selected groups the making of any firm recommendations is rendered increasingly difficult.

General Suggestion

It is suggested that if a partial care plan is introduced serious thought should be given that this plan begin by covering maternity and newborn care. Poor supervision and medical care during this period can so affect the future child that if it does not die, it may be left with an impaired state of physical and/or mental health. If the morbidity in this age group is not immediately tackled a heavy burden may well be placed on future health services. In many instances improvements in the field of research and improved medical care will keep alive children who have already suffered irreparable

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and irreversible damage. Any future complete health care (or Social Welfare) plan, may well find the increased number of these children a heavy burden.

Specific Suggestions

If a plan is developed which includes an extended or complete health care plan for selected groups, then it is suggested this plan should include:--

(1) Prenatal, natal, postnatal care of

(a) Preferably all mothers.

or

(b) If this is not possible then selected groups as recommended later in this report.

(2) Neonatal Period

Medical and surgical care in the neonatal period to:-

(a) All babies and this is more than a suggestion it is a recommendation.

(b) If this is not possible to certain selected groups.

(3) Birth to 16 years

It is suggested that if it is found necessary to introduct a limited care plan that thought be given to introducing one offering complete medical and surgical care to all children and young persons from birth to age 16 years.

(4) Present Rehabilitation Services

If (3) above proves impracticable then the present Rehabilitation Service offered through the Division of Maternal and Child Health, should be extended to provide care for acute illnesses as well as chronic

and irreversible damage. Any future comprehensive health (or Social Welfare) plan, may well find the increased [illegible]

Specific Suggestions

If a plan is developed which [illegible] tended or complete health care plan for selected [illegible] then it is suggested this plan should include:-

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(a) Preferably all mothers.

or

(b) If this is not possible then selected [illegible]

Medical and surgical care in the maternity [illegible] to:-

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(4) [illegible]

If (3) above proves impractical then [illegible]

[illegible]

to provide care for acute illnesses as well as [illegible]

conditions.

(5) Older Persons

Medical care for the older citizen is becoming an increasing problem, since older persons live longer, and make, on the whole, more calls of medical services, than those on the "working" years.

COST OF PLANS

It may be beyond the conpetency of the writer to consider cost of various plans, but it is of interest to note that the cost of services offered in other countries have tended to rise. One wonders if this % increase follows that of national income, or if the percentage rise of cost of the service is outstripping the percentage rise in the national income (assuming that at the same time other national expenditures continue to follow the same trend, so that relatively greater amount is not available to the Health Services).

It has been reported recently (February 11, 1961, B.M.J., editorial, p. 418) that the "Total cost of the service (i.e. the National Health Service of Great Britain) in the current year will be in the region of 867m. pounds of which the Exchequers share will be 663m. pounds. The gross cost this year is about 8% more than last year, and last years cost was 6% more than the year before that. The estimates for next year are likely to increase by 11%".

Their Minister of Health gave notice, in effect, that costs had reached a limit and further increase in costs would have to come from the consumer and to that and he announced changes in cost having increased

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substantially on a number of items for which charges had been made, it was proposed, therefore, to adjust these charges to the patient. These items included dentures, spectables, prescriptions (2/- each as from March 1st, 1961 instead of 1/- each) and welfare foods (asfrom June 1st). Thus orange juice which had been supplied at 5d a bottle became 1/6d, cod liver oil and vitamin tablets which had been issued free of cost became 1/- and 6d respectively. With these changes the health service contributions were also increased.

Mr. Powell concluded,

"There is an inevitable connection between the national income and what can be deployed on a particular service. It is the duty of those responsible for the respective services to see that priorities are preserved. By measures of this kind we ensure that the essential and growing elements of the Health Service can go forth unimpeded."

It may well be then that in the light of such experiences specific recommendations from us now on methods of keeping costs within certain limits might be relevant.

For these reasons a few paragraphs have been included on provision of special appliances, drugs, and grants to voluntary organizations.

<u>Population trends and effect of these and a better usage of medical services on hospitals</u>.

Predictions of population trends and their breakdown by age and residence are notoriously difficult to make. To know for how many a service might need to be provided, although basic, is by no means easy.

been made, it was proposed, therefore, to adjust these charges to the patient. These items included dentures, spectables, prescriptions (2/- each as from March 1st, 1961 instead of 1/- each) and welfare foods (as from June 1st). Thus orange juice which had been supplied at 4d a bottle became 1/6d, cod liver oil and vitamin tablets which had been issued free of cost became 1/- and 6d respectively. With these changes the health service contributions were also increased.

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Population trends and effect of these and a better range of medical service on hospitals.

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provided, although basic, is by no means easy.

To assess the results of these trends together with the effect of a fuller usage of presently available medical services if cost were not a factor, and to project for the future would be even more difficult. Nevertheless, before even a limited health care plan could be put into action it would be necessary to come to grips with these problems.

For this reason this brief report includes estimated figures, comments on present hospital facilities and future needs.

HOSPITAL NEEDS

It is difficult to discuss maternal health without reference to hospital facilities and standards and, therefore, some comments, criticisms, and recommendations were made under the section Natal and Post-natal care. Nevertheless a general note on this subject might be relevant. The effect on hospitals of increasing usage of present medical services and/or expansion of medical services must be considered.

Active Treatment Hospitals

Active Treatment hospitals should perhaps be considered as

1. Places to which sick are admitted for care as in-patients.
2. Places providing special services to out-patients.

The extent to which either or both of these are linked to sound home care plans involving Public Health Nurses and Social Workers, and Homes for the care of the chronic sick and handicapped will affect the number

To assess the results of these trends, [illegible]

[illegible] for a [illegible],

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2. Places providing special services to out-patients.

The extent to which either or both of these are linked to sound home care plans involving Public Health Nurses and Social Workers, and Homes for the care of the chronic sick and handicapped will affect the number

of beds per thousand population needed in active treatment hospitals and the services per thousand population that should be provided as out-patient care.

Population proportion trends and in-patients beds

Proportion of children and young persons in the population

Population proportion trends will affect bed needs. From this point of view it should be remembered that it has been calculated that by 1971 in New Brunswick 45% of the total population will probably be in this age group (birth - 19 years).

This will affect

(1) Bed distribution

(2) Number of paediatrically trained nurses required. The numbers required should be in training before the need for them occurs.

Out-patient services

If a total or partial care plan is decided upon the effect of decisions taken on out-patient and casualty services should be estimated.

Few New Brunswick hospitals are at present equipped for any development or increase in this field.

Link of Public Health Nurse with Hospitals

"For most patients hospital care is but an episode in a very much longer take of medical supervision"* and it well might be added nursing care.

It has been specified elsewhere that the link

* After Care of the Hospital Patient, B.M.J., April 29, 1961.

of b[illegible]

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* After Care of the Hospital Patient, R.M.J., April 4,

between the community and hospital nurse should be strengthened.

DRUGS

Provision of Drugs in Hospitals and on prescription through Clinics and private doctors

It would seem that if a medical care plan includes drugs certain principles should be considered.

1. Payment of token amount per prescription

It would seem necessary to require a token amount of payment towards each prescription. This should be at a flat rate, easy to be collected and except only specified, easily identified population groups. Nevertheless, it should not include

1. Those on Mothers' Allowance
2. Unmarried mothers
3. Possibly also those unemployed

2. Drugs to be prescribed

There should be a limit to the drugs that could be prescribed. As far as possible basic drugs should be prescribed. A formulary should be issued to the medical profession indicating which drugs might be prescribed and which might be available under special circumstances on application to special committees. Such a system would require Provincial committees composed of administrators, practising physicians and pharmacists.

3. Drugs purchased for hospitals

It is suggested that drugs for hospital use be bought in quantity by a central Provincial purchasing agency. That the cheapest of comparable products be

between the community and hospital nurses should be [illegible]

[illegible]

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That the cheapest of comparable products be

bought.

Again to quote the experience of the National Health System of Great Britain since literature from this country is continuously available to the writer.

"The annual bill for drugs prescribed in hospitals like the bill for those prescribed in general practice has been rising for some years. In the current financial year the total estimated cost of drugs in the Health Service is about 110m. pounds. It is made up as follows: Purchase by hospitals, 14m pounds; amount paid by chemists to manufacturers, 60m pounds; amount paid to chemists, 63m pounds. The following figures show the expenditure on drugs in the hospital service of Great Britain in 1955-61:

Year	million pounds
1955-6	8.3
1956-7	9.6
1957-8	10.7
1958-9	11.4
1959-60	12.4
1960-1	13.2

The increasing cost must be largely due, as it doubtless is in general practice, to the continual introduction of new drugs, which are necessarily more expensive at first. Whether they are more efficacious as well as more expensive than their predecessors is another matter. The way to test this is to try them by the stringent procedures that have become traditional in the best centres here."*

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2. This would include training at government expense doctors as specialists where there were not already sufficient of these specialists for the province or where they were not distributed according to the needs of the province.

These doctors in return for training bursaries should enter into a contract to serve for a given number of years in designated areas.

3. They should be assisted while settling by receiving government paid work on a fee for service basis where possible, (i.e. attendance at specialist clinics, etc.).

AMBULANCE SERVICE

Present position

Inadequate, but should not be provided from public funds.

REHABILITATION

1. Strongly recommended in this text is a change of practice in regard to the source from which orthopedic appliances and services are purchased.
2. It is recommended that consideration be given to building and staffing a second Rehabilitation Centre for the French-speaking areas of New Brunswick. This institution to serve all age groups.

CO-ORDINATION OF SERVICES AND THE ROLE OF THE MATERNAL AND CHILD HEALTH DIVISION

When the Division of Maternal and Child Health will no longer be concerned in the organization and payment of medical services for children the role of this Division in co-ordinating available services will become

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When the Division of Maternal and Child Health will no longer be concerned in the organization and payment of medical services for children the role of this Division in co-ordinating available services will become

stronger. The more services that are provided the more co-ordination will be required and I feel that the role will change from one of provision of direct services to the concept of acting as a link between existing agency services, developing communication with and among them, evaluating situations, and making recommendations. In view of the mobility of families and the changing social structure it is also probable that youth itself will need to become more involved in community life. Young persons will need to participate in some aspect of provision of service for children and young adolescents. This will probably mean some program of training and development of potentials in the older adolescent. It will certainly require education of adults who work with instead of working for young people and it may also require some education of parents to new concepts. The rate of change of environment in today's world is such that it is not always readily understood by the adult population. They can no longer rely upon family experience, the advice or understanding of their own parents and sometimes they are not in a position to understand their children. The more rapid the progress the more we will be dealing with the effects on adults. These effects, of course, will in some instances fall within the mental health field but in others will plainly require education in understanding of newer programs and procedures.

As we concentrate less on treatment we should be also concentrating more on Rehabilitation and prevention but as it would seem new syndromes will constantly be recognized it may well be that there will still be some

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role in treatment of groups rather than individuals for Departments of Health.

IMMUNIZATION

This has not been dealt with as it is felt that it would be the concern of the Director of Communicable Disease.

However, it is recommended that:-

(1) The ideal, and to be striven for, is a well immunized population (including booster shots).

(2) Children in long stay hospitals should not be forgotten.

(3) If a total care plan is introduced for children that private practitioner be encouraged to do more immunization.

This would encourage physician participation in positive health and relieve nurses time at child health conferencing so that more real conferencing might be undertaken.

PSYCHIATRIC SERVICES FOR CHILDREN

It is felt that this will be dealt with by the Director of Mental Health and no section is, therefore, included in this report.

Present Services

However, it is within the scope of the Director of Maternal and Child Health to point out that facilities in this province for the assessment and management of psychiatric disorders in children and adolescents are inadequate.

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Future

The way in which adequate services should be provided will no doubt be dealt with by the Director of Mental Health.

MENTALLY RETARDED

A detailed report to the Minister of Health for New Brunswick was prepared by the Director of Maternal and Child Health in August of 1960 and should be consulted for information on expected incidence and probable needs of different categories of mentally retarded children and young persons.

EPIDEMIOLOGY AND STATISTICS

An epidemiologist appointed to the Department of Health, together with a Statistician, would be of invaluable service in assessing health needs and trends.

It would seem useful for such persons to be added now to the staff to study such problems as exist and will surely arise with the extension of medical care.

PERSONNEL ENGAGED IN MATERNAL AND CHILD HEALTH WORK IN THE DIVISION OF MATERNAL AND CHILD HEALTH, DEPARTMENT OF HEALTH, AND THEIR GENERAL FUNCTION

From the plan of organization of the Health Department, it may be seen that many Divisions have an active interest in, and may carry out a part of the program of Maternal and Child Health. In addition each regional health group under its District Medical Health Officer is responsible for local programs.

The Division of Maternal and Child Health

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The Division of Maternal and Child Health

promotes health education and provides consultative as well as some direct services. In addition members of the Division of Maternal and Child Health work in close liaison with all others interested in this field whether Divisions of the Department of Health, other Departments or community groups.

It should be noted that there is no Faculty of Medicine in the Universities of New Brunswick.

STAFF OF THE DIVISION OF MATERNAL AND CHILD HEALTH

Physicians	2
Nutritionists	5
Nurse	1
Speech Therapist	1

POPULATION OF DIRECT INTEREST TO MATERNAL AND CHILD HEALTH

It has been calculated that in 1959 61% of the population was of direct interest to the Maternal and Child Health Division and it is expected that by 1971 this percentage will have increased to 64%.

Population:	Urban (2,500 and over)...	208,880
1959 estimate	Rural ...	381,786
	TOTAL	590,666

(a) Children and Young Persons - Estimated Population 1959

0-4	78,900
5-9	75,000
10-14	65,900
15-19	52,800
TOTAL 0 - 19	272,600 = 46% of total population.

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1959 estimate	Rural	...381,[illegible]
	TOTAL	590,[illegible]

(a) Children and Young Persons - Estimated Population

5-9	 75,000
TOTAL 0 - 19	[illegible] = 40%

(b) Women of child-bearing age - Estimated Population 1959

Age 20-44 years - 88,900 = 15% of total population.

Therefore, (a) + (b) = 361,500 = 61% of total population.

(a - b = % of population of interest to the Maternal and Child Health Division).

1971 Forecast

It is forecast that the population of the province will have increased to 706,600 by 1971 and that children and young persons will form a higher proportion, 49% against the 46% of 1959.

(a) Children and Young Persons - Forecast Population 1971

0-4	95,300
5-9	90,400
10-14	86,900
15-19	71,100
Total 0 - 19	343,700 = 49% of total population

(b) Women of Child-Bearing Age - 1971 Forecast

It is expected that the proportion of women in age group 20-45 years will remain at 15% of the total population and that there will be 104,500 of them.

(c) Population of direct interest to Maternal and Child Health is expected, therefore, to be 448,200 or 64% of the total population.

(b) [illegible]

Age 20-44 years - 83,900 = 15% of total [illegible]

Therefore, (a) + (b) = 201,500 = 51% or [illegible]

(a - b = % of population of interest to the Maternal and Child Health Division).

1971 Forecast

It is forecast that the population of the province will have increased to 706,600 by 1971 and that children and young persons will form a higher proportion, 49% against the 45% of 1959.

(a) Children and Young Persons - Forecast

0-4	[illegible]
5 - [illegible]	
[illegible]	
15-19	74,100
Total 0 - 19	343,700 = 49% of total population

(b) Women of Child-Bearing Age - 1971 Forecast

It is expected that the proportion of women in age group 20-45 years will remain at 17% of the total population and that there will be 104,500 of them.

(c) Population of direct interest to Maternal and Child Health is expected, therefore, to be 448,200 or 64% of the total population.

Note on Population Forecasts

For the purpose of this brief an attempt has been made to predict population changes in the coming ten years. Forecasts of population, like the weather, are liable to be confounded by events. Even the experts dealing with sovereign countries where reliable migration statistics are available have continually to revise their predictions.

It is all the more difficult in dealing with a part of a country since interprovincial migration is not recorded.

Out estimates of population for the coming year are based on Dominion Bureau of Statistics data and allows for the fact that New Brunswick differs in rate of population growth, age breakdown, and immigration from the national average.

It is assumed that the factors which have been taken into account operate at a uniform rate throughout each of the coming years.

Population Forecast, New Brunswick 1971

New Brunswick's increase in the twelve years preceding 1959, i.e. 1947-1959 was only 21.2% compared with 35.1% for the country. The D.B.S. predicts a 33% increase between 1959 and 1971 for all of Canada. If New Brunswick's increase in relation to Canada's continues as in the past we would expect New Brunswick's 1959-1971 increase to be 20% or, making the 1971 population 708,000.

The population of New Brunswick by five-year age groups for 1959 was obtained and each of these was increased by the expected increase for each group for

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The population of New Brunswick by five-year age groups for 1959 was obtained and each of these was increased by the expected increase for each group for

Canada and then scaled down to the revised level expected for New Brunswick. This gave the figures used in the body of the brief. The total for 1971 came to 706,600.

This relatively simple calculation was all that was done to arrive at our prediction.

The following checks were made to confirm that New Brunswick's population change in the period 1947-1959 was not typical of the country as a whole and differed from some other provinces.

1. The semi-logarithmic graph of Live Births, Canada and certain provinces shows clearly that the number of live births annually in New Brunswick has been practically static after the post World War II baby boom, as has P.E.I.'s, Nova Scotia shows a slight increase but not nearly as much as Quebec's or Ontario's and British Columbia's is increasing rapidly. Canada's has shown a very definite increase. Thus, New Brunswick is lagging behind Canada in the increase in the number of babies born each year.
2. The similar graph for Population shows that although New Brunswick's population has been steadily rising, its rate of increase is less than that of Quebec, Ontario, and British Columbia and less than that of Canada, although it is comparable to that of Nova Scotia.
3. The number of Immigrants who entered New Brunswick in each of the years 1954, 1957 and 1959 were obtained. These are related to population and immigration into all of Canada in the following table:-

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Canada

	Population	Immigrants	%
1954	15,287,000	154,227	1.02
1957	16,589,000	282,164	1.7
1959	17,442,000	106,928	0.6

New Brunswick

Population	Immigrants	%	N.B.'s rate of immigration compared to Canada
540,000	1,111	0.21	20.6%
565,000	1,674	0.3	17.8%
590,000	640	0.18%	30%*

*This percentage is high compared to the other two years but 1959 was a year in which immigration dropped to a low level. The Director, Immigration Branch of the Federal Department of Citizenship and Immigration in his 1959 Report remarks about the decline in immigration and points out that "in fact, the average immigrant intake for these three years (1957, 1958, 1959) is approximately 170,000 per year, which is almost exactly the annual average for the past decade".

It appears then that New Brunswick lags much behind the whole of Canada in the proportion of its population increase which is due to immigration. This may, of course, change given industrial development to attract immigrants.

4. The D.B.S. report referred to above also shows the percentage of families with children moving out of and into the various provinces during the period April, 1958 - March, 1959. This is shown in tabular form as follows:

	Population	Immigrants	%
[illegible]	[illegible]	[illegible]	[illegible]
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	Families with children moving out of province %	into province %	Percentage gain (+) or loss (-)
New Brunswick	3.2	3.6	+0.4
Alberta	3.1	3.5	+0.4
Ontario	1.3	1.4	+0.1
P.E.I.	3.8	3.9	+0.1
British Columbia	2.7	2.6	-0.1
Quebec	0.9	0.8	-0.1
Manitoba	3.2	3.0	-0.2
Newfoundland	1.4	1.2	-0.2
Nova Scotia	3.6	3.2	-0.4
Saskatchewan	3.3	2.9	-0.4

Table: Percentage of families with children changing province - April, 1958 - March, 1959.

This shows that New Brunswick (with Alberta) heads the list for population gain by interprovincial migration of families with children. It is not known whether the fiscal year 1958-1959 is typical of the decade nor is the number of individuals affected known.

The above reveals our method of calculation of New Brunswick's 1971 population. The calculation is crude, but we have no statistician on our staff, still less anyone skilled in population predictions.

HEALTH AGENCIES (OTHER THAN GOVERNMENT)

General

Nearly all of the national health agencies have active branches in New Brunswick. These are of two kinds -- professional organizations and voluntary agencies. The former consists of associations of professional persons,

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Quebec	0.9	0.8	-0.1
[illegible]	[illegible]	[illegible]	[illegible]
Newfoundland	1.4	1.2	-0.2
Nova Scotia	3.6	3.2	-0.4
Saskatchewan	3.3	2.9	-0.4

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Nearly all of the national health agencies have active branches in New Brunswick. These are of two kinds -- professional organizations and voluntary agencies. The former consists of associations of professional persons.

e.g., the New Brunswick Medical Society, the New Brunswick Registered Nurses' Association, etc. These and their national bodies have done much to improve professional standards, to encourage research and promote programs.

The voluntary agencies comprise a large number of different types of organizations and their number has increased considerably in the past decade. They may be subdivided into:

(a) the religious orders which provide hospital services. These provide a very considerable proportion of the hospital beds in New Brunswick. The order with the largest number of hospital beds in the province is the Hotel Dieu de St. Joseph.

(b) pre-payment medical care plans

(c) a large number of voluntary service agencies concerned with certain aspects of public health work and supported by public donations and, sometimes, government grants.

The New Brunswick Red Cross Society is principally concerned with the provision of blood banks, public education in water safety, disaster relief, and direct help to persons in need. The blood bank program is one of the essential services for the health of the province. It functions most efficiently and is making a very valuable contribution to Maternal and Child Health. The Junior Red Cross has important functions in connection with child health; such as the distribution of Vitam "A and D" capsules to school children and assistance to families needing help with transport and maintenance when a child visits

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specialists or is admitted to hospital in places far from home.

Recommendation

It is recommended that the blood bank program continue as at present.

The St. John Ambulance deals primarily with first-aid and transport of infants in incubators supplied by the Department of Health and of children and adults to various government sponsored clinics.

The question of the transport of newborn infants has been dealt with in another section of this report. The present position is highly unsatisfactory. Voluntary personnel are often not available when required for emergency cases. Furthermore, their training is usually inadequate for the care of infants who need continuous specialized care during transport.

Recommendation

We recommend the provision of an adequate provincial ambulance service for the transport of sick infants and children and certain cases of obstetrical emergency. Such ambulances to be suitably staffed.

The Victorian Order of Nurses supplements the work of the Department of Health in the provision of public health nursing for Maternal and Child Health as well as providing bedside nursing service in certain towns and cities.

The Victorian Order of Nurses are rendering services in the field of Maternal and Child Health which are excellent in quality but, at the present time, their work is handicapped by lack of personnel.

specialists or is admitted to hospital in places far from home.

Recommendation:

It is recommended that the blood bank program continue as at present.

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The Victorian Order of Nurses are rendering services in the field of Maternal and Child Health which are excellent in quality but, at the present time, their work is handicapped by lack of personnel.

Recommendation

It is recommended that this service be extended as much as required and that programmes carried out with the aid of government grants be well supervised by the Department of Health and integrated into the total public health program of the province.

Other Service Agencies

Many of the other service agencies are concerned exclusively with a particular disease or disability. The following is a list of some of them with branches in New Brunswick:

Canadian Association for the Mentally Retarded
Canadian Council for Crippled Children
Canadian Arthritis and Rheumatism Society
Canadian Poliomyelitis Foundation
Canadian Hearing Association
Canadian Cystic Fibrosis Foundation
Canadian National Institute for the Blind
Canadian Paraplegic Association
Canadian Diabetic Association
Canadian Tuberculosis Association
Canadian Mental Health Association
Multiple Sclerosis Society of Canada
The Muscular Dystrophy Association of Canada
(No branch but activities sponsored by special groups)

A number of these belong to the New Brunswick Co-ordinating Council for the Handicapped.

The services provided by these agencies in New Brunswick include transportation of children and their escorts to hospitals or for specialist consultation, etc.,

It is recommended that this service be extended

the aid of government grants be well supervised by the Department of Health and integrated into the total public health program of the province.

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(No branch but activities sponsored by special groups)

A number of these belong to the New Brunswick Co-ordinating Council for the Handicapped.

The services provided by these agencies in New Brunswick include transportation of children and their

and treatment, purchase of certain appliances and drugs. In addition, most carry on some form of health education of the public. There seems to be a desire in all for participation in case finding and research.

With the introduction and extension of services for handicapped children under government grants and particularly the recent expansion of the Junior Rehabilitation program, the Department of Health can now provide treatment, including most forms of appliances, to children with chronic disabilities or for the prevention of chronic disability. This type of service need, therefore, no longer be provided by service agencies.

The voluntary agency has a proud history of pioneering health projects and providing services to meet those needs. Such pioneering efforts have sometimes resulted in government provision of the services shown by the agency to be necessary after which the voluntary agency usually relinquishes the field to the official service. In most cases such agencies have found other worthwhile projects to embark on, such as research, critical appraisal of the use of services, disclosure of other needs or gapa in service, etc. Despite this, some of these service agencies continue to provide treatment for some of these children who come to their attention and on occasion they even collect money from the public for this purpose. This is undesirable because the voluntary agency does not provide as continuous or efficient a service as the government does in the diagnosis and treatment of illness or disability and there is no need either for duplication of services.

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Recommendation

1. It is urged that the service agency should be encouraged to educate the public to make use of existing services and to supply services only where none are provided publicly or where they are insufficient and that government grants should not be given to any organization duplicating services.

2. It is recommended that service agencies dealing with similar or related diseases or disabilities be encouraged to amalgamate their programs so as to avoid the multiplicity of organizations that exist today, e.g., the Multiple Sclerosis Society, Paraplegic Association, Poliomyelitis Foundation and the Arthritis and Rheumatism Society might well combine together since they all deal with locomotive disabilities.

In addition, such voluntary health groups be encouraged to join the Co-ordinating Council for the Handicapped to prevent wastage from overlapping of services and to insure integration and co-ordination of programs.

3. It is strongly recommended that the whole question of the provision of government grants to these organizations be reviewed. It is suggested that grants be allocated, if at all, for the rendering of specific services approved by the Department of Health and that these organizations regularly submit financial accounts and reports of the use of which these monies have been put.

4. It is recommended that the Department of Health increase its program of education of the public in order that they may be aware of the services provided by the government so that if voluntary organizations collect

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4. It is recommended that the Department of Health increase its program of education of the public in order that they may be aware of the services provided by the government so that if voluntary organizations collect

money from the public for such programs that the public be aware that they are contributing twice; by tax and by voluntary donation.

PRENATAL CARE

Numbers of prospective mothers who should be receiving care

The estimated number of women who should be receiving prenatal care in New Brunswick in any one year is at present 24,750 and the number of women who should be receiving prenatal care at any one time is approximately 9,600.

While advocating early prenatal care it is recognized that a varying and unpredictable number of women might come under care during the second and third months and for this and other reasons figures for the first trimester are not included. However:

No. of maternal deliveries resulting in a birth in 1959 = 16,500. Therefore number of pregnant women in second or third trimester in any one month who should be receiving prenatal care = 9,330. The number of women who were in the second or third trimester during 1959 was 24,750. Therefore, 24,750 should have received prenatal care in the course of the year.

General

Information is lacking on the proportion of expectant mothers who receive prenatal medical supervision during that period. An inquiry into breast feeding in 1954-55, however, revealed that 85% of 1,064 mothers with infants had received some medical supervision prenatally but the quality of the prenatal care was not known. It

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would appear, however, that 15% of mothers went into labour without having visited a doctor even once during pregnancy.

There is good reason to suspect that among the 85% who did have some prenatal care that the quantity of the care was deficient.

Not much more is known today about the number of prospective mothers receiving prenatal care or the quantity of the care.

1971 Forecast

It is expected that the number of maternal deliveries will rise from the present 16,500 to 19,200 in 1971 so that the total number of women who should receive prenatal care will be 28,800 and the number who should be under surveillance at any one time will be 11,200 (based on the population in their second and third trimesters of pregnancy.)

1960-1961

Services available

A. Prenatal Classes

Prenatal classes were held in four centres during the past year. In one centre classes were continuous, in the three other areas intermittent. Attendance at these classes covered but a small percentage of women pregnant in the communities where these classes were held and an even smaller number of New Brunswick's population who might have benefitted from this service.

These classes were undertaken by V.O.N. and hospital nurses.

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These classes were undertaken by V.O.N. and hospital nurses.

Conclusion

The value of prenatal education for prospective parents has apparently not been sufficiently recognized.

Recommendation

It is recommended that prenatal classes be conducted in all urban areas and available in as many rural centres as possible and that at the same time there be an accelerated program to prospective parents and the medical and nursing profession making known the benefits of such programs.

Suggested ways of expanding program

1. It is recommended that the program of prenatal classes be co-ordinated and developed by the Division of Maternal and Child Health. This is important as

(a) The cooperation of the medical profession is necessary to this program.

(b) There must be one co-ordinating centre to collect information on the functioning of the program since several agencies and professional groups would be involved (i.e. the medical profession, hospital nurses, Department of Health, Public Health Nurses, V.O. Nurses, Red Cross Nurses, and possibly physiotherapists). Continuous and satisfactory information is necessary for the program evaluation which should be made by this Division. This program would be sufficiently valuable by its contribution to prevention of maternal and infant mortality and morbidity to be worth the cost of service

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involved.

2. Organization of Classes

(1) Regular and probably continuous classes should be held in larger urban areas (Moncton, Saint John, Fredericton, Edmundston, Bathurst, etc.). It is suggested that these should be held in out-patient departments of general hospitals and that they should be taught by a suitably trained nurse on the staff of the hospital and/or Public Health Nurse.

(2) It is suggested that in all other areas having a population of 3,000 or over classes should be organized at definite and regular intervals. These should be held in hospitals where possible, otherwise, in sutiably selected quarters and by the Public Health Nurses.

(3) It is suggested that in areas of less than 3,000 population classes would probably not be practical and therefore the Public Health Nursing Service should be prepared to make home visits to these patients, unless some system of transport could be devised to get these prospective mothers to centres where classes are behing held. It is possible that in this group of patients a combination of these two systems would be possible.

B. Private medical care

(1) Private Physicians

General Practitioners

Many practising physicians have informed us of the difficulty of inducing women to come to them

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Private medical care

(1) Private Physicians

Many practising physicians have informed us of the difficulty of inducing women to come to their

early in pregnancy and have stated that a fair proportion seek medical attention only late in pregnancy.

Comment cannot be made on the quality of services offered and rendered.

(2) Obstetricians

In the last four years 1956-1959 seventeen out of the twenty-eight maternal deaths occurred in the three northern counties of Gloucester, Restigouche and Northumberland; the remaining 11 deaths occurred in seven counties. This preponderance happens to fall in counties where there is only one obstetrician between two of them (i.e. Gloucester and Restigouche Counties) and where in addition there were in 1959 the highest number of deliveries unattended by a physician.

Without further investigation it would not be possible to determine which of these factors is of the greater importance but obviously either together or separately might have affected the issue. It may well be that these counties need a free "flying squad" service in addition to other services recommended.

Conclusions

1. Full use is not made of existing physicians' services. We do not know but suspect that the reason for this is often an economic one. Education is also required on the value of classes.

2. We have no information on number of prenatal visits

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Conclusions

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paid by pregnant women to their physicians or of the pattern of care offered.

3. Obstetricians are not distributed in the province on the basis of need.

C. Prenatal Clinics

(Staff - Doctor and Nurse)

There is at present no such clinics in New Brunswick either separate from or in out-patient departments of our larger hospitals.

RECOMMENDATIONS

1. That a survey be made of the present position in prenatal care

Such a study should include:

(a) Percentage of pregnant women who visit their family doctor during pregnancy.

(b) Number and timing of visits.

(c) Routine tests and examinations carried out.

(d) Quality of record keeping.

(e) Reasons why a fair proportion of prospective mothers do not visit doctor during pregnancy.

2. Prenatal Care - General

That prenatal care be made available to all pregnant women in New Brunswick by whichever means is most practical and that if this is not acceptable then that it should definitely be provided free of cost to:

1. Prospective mothers whose husbands are disabled, dead, in mental hospitals, or sanatoria.

of the pattern of care offered.

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Prenatal Care - General

That prenatal care be made available to all pregnant women in New Brunswick by whichever means is most practical and that if this is not acceptable then that it should definitely be provided free of cost to:

1. Prospective mothers whose husbands are disabled, dead, in mental hospitals, or

2. Prospective unmarried mothers of under 21 years of age.

3. Whose husbands are unemployed and the mother under 18 or over 45 years of age.

3. Prenatal Clinics

If a complete program of care is not established it is recommended that Prenatal Clinics be established.

(a) Urban Areas

In urban areas prenatal clinics should be established so that pregnant women who feel unable to afford the fees of private physicians may receive prenatal care.

These clinics should be staffed by members of the local medical group, preferably by obstetricians, paid by the Department of Health, or provided as part of a medical care plan.

(b) Rural Areas

That a physician periodically visit rural areas to hold clinics. The physician might be a member of the local medical profession or a member of staff of the Department of Health doing a number of rural clinics and with an office appropriately situated considering the areas to which the service would be offered.

4. Records

It is further recommended that:-

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3. [illegible]

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4. Records

It is further recommended that:-

Prenatal records be kept by practising physicians, that such records be sent to local hospitals so that they are available in hospital at the expected time of delivery where possible, otherwise soon afterwards. Such records to be made available for study to the Department of Health. (This form itself might be provided by the Department of Health.).

5. Laboratory Services

Such laboratory services as are necessary for prenatal clinic patients should be provided free of cost.

Number of married women with children in New Brunswick receiving assistance from Mothers' Allowance under the Social Assistance Act, Part 1, as of August 31, 1961

2,152 mothers were assisted who together had 6,345 children. Of these were:

1. Widows.....1022
2. Have husbands but receive allowance because:
   - (a) Husband disabled.....223
   - (b) " in sanatorium.....216
   - (c) " in Provincial Hospital.....171
   - (d) " receiving assistance and training through the Rehabilitation Division.....9
   - (e) " deserted family.....361
   - (f) " convalescing from tuberculosis.....118

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(d) " receiving assistance and

Rehabilitation Division.....0

(e)

(f) " convalescing from tuber-

culosis..... 118

(g) " convalescing after stay in Provincial Hospital.....22

2,142

NATAL AND POST NATAL CARE

A. General

(i) Maternal Mortality

1959 - N.B. rate -- .4/1000 live births

1960 - N.B. rate -- .6/1000 live births

The numbers involved are small so that the rate tends to swing but, in general, we have a rate similar to that of the national average.

(ii) Maternal Morbidity

However, about maternal morbidity we have relatively no information.

RECOMMENDATION

It is recommended that a survey be carried out in Canada and from our point of view particularly in New Brunswick designed to give information in this field.

B. Deliveries

(i) Hospital Deliveries

97.6% of New Brunswick babies in 1960 were delivered in hospitals.

Home and other deliveries

Approximately 2.4% of deliveries were delivered at home or on the way to hospital in 1960.

(ii) Physician Attendance

While figures are not available for 1960, in 1959, 175 babies were delivered without benefit

(g) " convalescing after stay in

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of a physician in attendance. Not all of them certainly were born before arrival of a physician. It is significant that 140 of those occurred in two Counties, namely Gloucester and Northumberland.

C. Hospital beds relative to present and future usage

It should be noted that while there has been a great increase in hospital births the number of hospital beds set up and rated as of December 31st, 1960 has not greatly changed in regard to beds set aside as maternity beds. The overall picture is difficult to determine due to the fact that smaller hospitals do not designate beds for a specific purpose. (See Table)

The introduction of a comprehensive care plan would not because of the present high percentage of hospital deliveries, materially affect the bed situation. Nevertheless, the present facilities should be surveyed with the thought in mind that between 97 and 99% of hospital deliveries might occur in the future, together with increase in population it is questionable whether our hospitals are physically equipped for this load, or a sufficient number of trained nurses as yet available.

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DISTRIBUTION OF BEDS RATED AND SET UP, 1958-1960*

Type of Beds	Beds set up and rated as of December 31 1958	1959	1960
Maternity			
Rated beds	447	479	500
Beds set up	443	452	459
Pediatrics			
Rated beds	389	466	475
Beds set up	462	510	519
Bassinets			
Rated Beds	520	613	613
Beds set up	578	607	626
Beds not distributed as to type			
Rated	155	76	75
Set up	189	89	90
Total: All beds			
rated	2473	2845	2858
set up	2699	2912	2992

* Excluding Polio Clinic, Forest Hill and Moncton Annex.

Please note that visits to hospitals in the province this year showed that improvements are necessary.

CRITICISMS OF EXISTING NEW BRUNSWICK HOSPITALS 1960

10 had no labour room

5 had no room used exclusively for maternal deliveries

[illegible]

Type of Ward [illegible]

	1950		
Maternity			
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Beds set up	443	452	459
Pediatrics			
Rated beds	389	466	475
Beds set up	462	510	519
[illegible]			
Rated Beds	520	613	614
Beds set up	573	607	626
Beds not distributed as to type			
Rated	155	76	17
Set up	180	89	90
Totals: All beds			
rated	2473	2945	2855
set up	2599	2812	2905

* Excluding Point Orinio, Forest Hill and Moncton, Amer.

Please note that visits to hospitals in the province this year showed that improvements are necessary.

CRITICISMS OF EXISTING NEW BRUNSWICK HOSPITALS 1950

10 had no labour room

5 had no room used exclusively for maternal

11 had no paediatric isolation facilities

9 have unsatisfactory utility room facilities.

Hospital Standards affecting maternal and infant health

Standing orders for nurses with regard to maternity care (labour, and delivery and postpartum) and newborn care is lacking in some hospitals. We believe that all hospitals should have such standing orders and that they be approved by an authoritative body.

Again, our 1960 hospital visits showed that improvements are needed.

CRITICISMS OF CERTAIN STANDARDS IN NEW BRUNSWICK HOSPITALS 1961

12 had nursing supervisors who had not received post-basic training in maternity and newborn care.

7 had no standing orders for nurses on maternity and newborn care.

4 did not bring bottle fed babies to their mothers for feeding.

17 did not autoclave baby linen

2 did not wash baby laundry separately (for 3 hospitals this information is missing).

5 did not have satisfactory formula preparation.

6 still have serious deficiencies in control of Cross Infection due to poor housekeeping or the difficulties of the physical set up or general lack of interest.

RECOMMENDATIONS

1. That natal and postnatal care be available to all New Brunswick mothers without direct

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[illegible]

1. That ostal and postnatal care be available to all New Brunswick mothers without direct

payment of fee and that if this is not possible that

(a) A study be made of all New Brunswick births unattended by a physician to discover whether these patients would have sent for a doctor if they could have afforded the service, or whether they were satisfied with some other service.

(b) Prenatal clinic patients be referred to the hospital for delivery, and that they be charged no fees providing that they have made a minimum specified number of prenatal clinic attendances, and that the fees for medical service to this class of patient be paid by the Department of Health or through some medical care plan.

(c) That natal and post-natal care without direct payment of fee be provided for the following categories of pregnant married women:-

(i) Those whose husbands are dead, disabled in mental health hospitals or sanatoria

(ii) Those below 18 years or over 45 years and for unmarried mothers under age 21 years (see special note Illegitimacy)

2. Legislation should be introduced to make it illegal for anyone other than a qualified and duly registered medical practitioner to carry out midwifery, except

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in cases of extreme emergency.

3. Certain New Brunswick hospitals do not yet meet suitable standards of obstetrical care, it is therefore recommended that these hospitals be brought up to certain minimum levels in regard to physical plant, equipment and standards of care.

Medical practices regarding the care of the woman in labour and her postpartum care very tremendously. We believe that the Department should, with the advice of the profession produce as a guide to the profession what should be considered minimum standards, especially in relation to:

(a) analgesics and anesthetics

(b) use of forceps

(c) induction of labour

NURSING CARE

This starts in the prenatal classes and hospital with advice to the mother on personel care, care of the breasts, clothing, etc. It should be continued after discharge from the home by the Public Health Nurse.

If the transition from hospital to community is to be most advantageously made by mother and baby the Public Health Nurses need to be more closely linked to the hospitals.

RECOMMENDATION

It is recommended that a room be made available in all hospitals for the Public Health Nurse. This to be used

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visits from newborn nursery (multiple births,

premature babies, sick babies, babies from problem families).

(2) Interviewing mothers while in hospital and before discharge.

(3) Teaching where this is a part of her program (pre and postnatal classes, etc.).

(4) Where she may be seen by physicians, nurses, social workers, wishing to transmit to her information concerning parents due for discharge to whom she will pay; home visits for nursing care or guidance, counselling, or health education.

POSTPARTUM CARE (after discharge from hospital)

1. Nursing Aspects

These have been dealt with above.

2. Medical Examinations

A medical examination about six weeks after delivery should be available to every post woman. Such an examination should include a pelvic examination.

RECOMMENDATION

We recommend that means be found to make this postnatal medical visit and examination available to all, and if not all, certainly to those who cannot afford the cost, and this should in particular include the special groups already mentioned under prenatal and natal care.

STILLBIRTHS AND PERINATAL MORTALITY RELEVANT STATISTICS

It should be noted that the New Brunswick still birth rate was the fourth highest in the provincial lists in 1959 and was higher than the national rate. The

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perinatal death rate was 31.0 for New Brunswick in 1959, while the national average was 28.9.

COMMENTS

The quality and availability of prenatal care is nowhere better reflected than in these figures. Therefore the recommendations already made in relation to prenatal and natal care apply here. In addition it should be noted that specialist obstetrical care is not distributed throughout the province on the basis of need. It seems that the loss economically favoured regions where specialist obstetrical care might be considered more necessary have a present a paucity of services.

The placement of specialists, obstetricians and paediatricians should be related also to the number of births. It should be noted for example that Saint John with six specialists is surrounded by the three counties of the lowest birth rate, i.e. Charlotte, Queens and Kings, and that Campbellton with one specialist is surrounded by counties with the highest birth rates, with the exception of Sunbury, i.e. Madawaska and Gloucester.

NEONATAL DEATHS

Relevant Provincial Statistics

(a) The New Brunswick neonatal death rate in 1960 was 16/1000 as against 19/1000 in 1959, a decrease which is not considered to be statistically significant.

(b) Comparison with national figures

While our neonatal mortality rate is approximately that of the national figure it should be pointed out that, compared with other countries, Canada ranks 8th which is significant when it is considered that

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Canada as a whole was only 25.8%.

There is undoubtedly an association between medical care, its quality and availability, and many of our neonatal deaths.

RECOMMENDATIONS

Premature Care Hospitals

1. It is recommended that every effort be made to improve hospital standards of premature care in medium and large hospitals. This would include:-
   (a) Renovations to the physical plants where necessary
   (b) Provision of an adequate number of incubators of suitable type
   (c) An adequate and continuous program of training for
      (1) Nurses
      (2) Physicians

      in premature baby care.
2. It is recommended that facilities be made available for the transfer of premature babies where necessary from very small hospitals to larger units. This would imply sending a nurse with proper knowledge of care and transport of such infants from the larger hospital or from some special centre to accompany the baby. The reverse implies a special knowledge on the part of nurses in smaller hospitals which they may not, and probably will not have. Transport should be at no cost to parents and in suitable vehicles well equipped with modern portable incubators.

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FOLLOW-UP VISITS

1. Public Health Nurses

It is known that at present slightly less than 1/3 of all New Brunswick babies receive visits from Public Health Nurses during the neonatal period. It is also certain that even that number do not receive adequate counselling during the early months of life or the whole of the first year.

It is therefore recommended that a sufficiently large staff of Public Health Nurses be employed to ensure that this important supervision and guidance is available.

2. Physicians

It is recommended that medical care be available for premature infants born to parents who cannot afford the necessary medical fees.

CHILD HEALTH

A. Infant Deaths

1. Main Causes of infant deaths in New Brunswick

(1) Respiratory Disease

The main cause of death in the eleven months following the meonatal period is respiratory infection. These infections were responsible in 1959 for 48.8% of the province's infant deaths.

(2) Congenital Malformations

A further 12.7% of infants died as the result of congenital malformation in 1959.

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(3) Accidents

11.3% of infant deaths in New Brunswick in the same year were due to accidents.

II Infant Deaths unattended by a Physician

In 1959 there were a not insignificant number of deaths occurring in infants for which no medical certificate of death was issued. Few of these were fully investigated by autopsy.

RECOMMENDATIONS

1. Prevention of Disease and Promotion of Health

All infants should receive adequate health supervision to assist prevention of disease and promotion of health. (See below under health supervision)

2. Diagnosis and Treatment

Medical care should be available to all sick infants where family unable for financial reasons to provide this care.

3. Deaths unattended by a physician

We recommend that all of these cases be dealt with by the coroner and that the coroner be encouraged to arrange for a post-mortem examination to establish the cause of death.

B. Infant Morbidity

1. Respiratory infections

The prevalence of respiratory infections in infancy is well known and too often taken for granted by the mother. Education in this sphere would be a part of health supervision in Child Health Conferences.

(3) Accidents

11.3% of infant deaths in New Brunswick in the same year were due to accidents.

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2. Respiratory Infections

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2. Nutrition problems

Nurses at Child Health Conferences should discuss feeding problems and give standard advice on good food habits. They should encourage breast feeding and be prepared to interpret the recommendations of the family physician on formula preparation and mixed feeding. The importance of increasing health education in this field is shown by the fact that 88 cases of Scurvy were recorded as being hospitalized in New Brunswick in 1960. Most were in this age group. A study of cases hospitalized from July 1st, 1959 - June 30, 1961 is at present in progress. These accounted for 1,440 hospital patient days in the first 18 months of hospital insurance. (It is interesting to speculate on the total cost of these cases to the Province in these the first complete years of Hospital Insurance.) Breast feeding is a protection against scurvy and is a further reason for encouraging mothers to start and continue babies on breast milk. However, the two main factors resulting in cases of scurvy seem to be ecomonic and lack of sound knowledge of infant feeding.

It may well be that supplements should be provided to certain selected infant groups (i.e. those whose mothers receive Mothers Allowance, fathers unemployed etc.) but in any case provision of supplements alone would not be the answer, education is also necessary.

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3. Safety Education should be an integral part of Child Health Conferences introduced on a developmental basis. This means parents would be made aware of the infants present developmental stage with its dangers and the stage the infant might be expected to reach before its next visit so that parents would understand hazards associated with each stage of infant growth.

4. Teaching of good general health practices should be a part of the nurses conferencing in Child Health Conferences.

C. Suggested plan of health supervision in infancy and preschool years Child Health Conferences

It is suggested that the following be considered a guide to the number of visits and that this represent minimum rather than ideal standards.

Age of Child	Frequency of medical examinations or visits by Public Health Nurses for supervision and counselling
Birth - 5 months	Monthly
6 - 11 months	Once every two months
1-4 years	Twice a year
5 years	Once

From the above schedule each child would thus have a minimum of eighteen consultations monthly (or 281,000 in the year) would have been necessary. With the increase in size of the population of this age group to 113,380 by 1971 the number of

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consultations necessary per month will probably rise to 28,360 or 340,320 in the year.

The Present Position

It is not known how many infants and children visit their doctors for health surveillance but we have good reason to suspect that such visits are rare, at least outside the three largest cities. Information on the number of infants and children whose mothers receive adequate health counselling from public health nurses (government and voluntary) is incomplete. It is recorded that there were 151,637 attendances by visits to infants and children. Most of these (129,543) were attendances for immunizations. It appears then that in 1959 nurse-child contact alone achieved more than half, actually 54% of the total recommended for all children in the 0-5 age group, although in the majority of such contacts little or no counselling took place. Regular attendance at Child Health Conferences at which the nurse should have time to instruct mothers individually or in groups, is a valuable measure in imparting knowledge for the protection of the infant and in detecting cases which require medical consultation. The nurse should be available to visit infants in the vicinity of the conference if this area is far removed from a doctor's office or residence. Comments will be made later on deaths due to accidents.

RECOMMENDATIONS

1. That frequency of health appraisal examinations

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That frequency of health appraisal examinations

should bear a relationship to the age of the child and to health needs. Nevertheless, it is recommended that as soon as possible a standard be reached such as recommended above.

2. That the importance of the regular health supervision of infants and preschool children be stressed in health education of the public.

3. That where possible the medical profession be encouraged to consider regular health supervision as part of the normal duties of the family doctor and that professional education include this as a subject.

4. That advantage be taken of all nurse-child contacts to provide adequate health counselling. To achieve this it is suggested that at immunization clinics efforts be made to relieve one nurse at least from injection duties.

5. It is recommended that adequate provision be made for periodic health appraisal of infants by Public Health Nurses with the possibility of referral, where necessary, to private physicians or clinics at no cost to the parents at least where parents could not otherwise afford these services.

Special Supervision by private physicians and paediatricians

It should be recognized that some children require much more supervision than others.

Infants whose mothers have suffered uterine bleeding or toxaemia should receive more special care as should those with a history of premature birth, birth injury, jaundice, convulsions and congenital defects.

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These infants should have predominantly medical care and preferably this care should be by paediatricians. This continuous medical care should be available to all such children irrespective of parental ability to pay.

It is suggested that this care be provided through out-patient services in large urban centres or expansion of the present paediatric clinics and through an extension of our paediatric clinics in other areas.

D. Preschool Child

General Comments

From the time when immunizations have been completed and until children reach school age they receive little public health attention as a group.

If children are ill they may come to the attention of the family doctor but in general if they have special problems and if these come to the attention of health personnel the children may be referred to one of the diagnostic or treatment services offered by the Department of Health (i.e. Paediatric Clinics, Metabolic Clinics, Mental Health Clinics, etc.).

It can be assumed that there is little positive health promotion or preventive work done in this age group.

This situation is highly unsatisfactory.

Causes of death in this age group

In New Brunswick in 1959 the chief cause of death from 0 - 4 years was respiratory disease. From 5 - 9 years accidents were the leading cause of death.

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Morbidity in Preschool Child

There is little information on the health of children in New Brunswick in the preschool years. However, it is important to note that a not inconsiderable number of children have come to our attention as suffering from some form of malnutrition, including scurvy.

RECOMMENDATIONS

I General

It is evident that a more vigorous program of safety and nutrition education to parents is required and a more continuous pattern of child health care during these years.

II It is specifically recommended that:-

1. Accident Prevention be regarded as a definite part of the program of the Maternal and Child Health Division of the Department of Health, and that staff be allotted to the Division for that program, and that they work in the fields of accident prevention not covered by other organizations. In particular Home Safety should be an important concern of this Division. Education of parents in this field is of the utmost value. Also each accident reported to a family doctor and certainly all those resulting in hospitalization should be followed up by a Public Health Nurse, information transmitted to the Division of Maternal and Child Health and guidance and advice given to the family at a time when they may be sensitive and responsive to safety education.

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Furthermore counselling in safety should be an integral part of the program at Child Health Conferences.

2. Child Health Conferences (See separate recommendation)

3. Medical Care of Preschool Child

It is recommended that either a medical plan should include provision of medical care for these children or the present Rehabilitation and Paediatric Clinic Service be supplemented by an extension of the out-patient and public ward system (such as operates in the Saint John General Hospital).

E. School Health

Introduction

In school health supervision the early detection of health deviations is a desirable goal so that early treatment may be effective or at worst ill-effects be minimized.

It is difficult to evaluate present school health supervision and, therefore, a committee was set up in 1960 to do this. It is equally difficult to foresee how it should develop since the number of health workers is unlikely to allow of very intensive programs in any direction. There will probably always be difficulty in establishing priority in public health programs, in selecting the method of approach, in deciding whether direct or indirect service is required, whether service should be purchased or supplied, and finally

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whether official regulations or standards might be of assistance in any situation.

It would seem that the individual examination is not the most rewarding method of tracing defects. The tendency seems to be towards screening programs which result in the collection of specific and factual information. Such screening methods may be based on

(1) Routine periodic examinations, e.g. an annual audiometric examination, or

(2) They may be selective (e.g. examination of children selected on the basis of questionnaires sent to parents, teachers and/or family doctors), or

(3) There may be a routine single examination, for example audiomatric examination of all third grade children or of all school entrants, or

(4) Any combination of the above may be decided upon.

Numbers at present requiring supervision

There were 139,950 children in grades 1 to 13 in publicly controlled and private schools in June, 1960. These children were in 58,006 classrooms with 5,806 teachers in 1,410 buildings.

Present System of school health supervision

Health supervision is at present mainly carried out by the teacher referring children to the Public Health Nurse. This system places the responsibility for the detection of health defects on the teacher. To be effective such a system requires that teachers be well

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In fact, such teaching is a part of the curriculum of Teachers' Training College in Fredericton given by Public Health Nurses, but unfortunately caters for only a proportion of the teachers employed in Provincial schools. In practice, teacher referrals are very patchy, being good in some schools and poor in others.

Were the referral system to be conscientiously and diligently used by all teachers it would increase the Public Health Nurses' work considerably. It would appear then that the number of nurses engaged in this work would have to increase.

At present, apart from mass miniature X-ray, screening for particular health defects is not universal.

Suggestions

1. Orthopedic defects

As the number of Physical Education instructors increase more referrals may be made to the Public Health Nurses of posture disorders of the locomotor system.

2. Audiometric testing

Testing of all or selected students by audio-

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Audiometric testing

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meter should be a routine part of school health supervision and done at regular intervals throughout school life, probably three or four times in all. These routine screening tests should be a part of the Maternal and Child Health services and staff should be members of that Division. Staff should be especially trained for the purpose.

They should be teachers or nurse with additional training in audiometric testing and field training under supervision of the Director.

3. Assessments of Visual Acuity

1. All school entrants should be tested.
2. This should be repeated according to the availability of Public Health Nurses but should be done in grades 6 and 9.

4. Medical Examinations

It might be considered whether, if a health care plan includes medical services to all children, school entrants should receive a medical examination from the family physician. For this examination a standard form could be used so that immediate and longitudinal studies could eventually be made of health of school entrants as it appeared from these examinations.

5. Questionnaires

Failing this, it is suggested that the present system of referrals be supplemented by more information from parents.

meter should be a routine part of school health supervision and done at regular intervals throughout school life, probably three or four times in all. These routine screening tests should be a part of the Maternal and Child Health services and staff should be members of that Division. Staff should be especially trained for the purpose.

They should be teachers or nurses with additional training in audiometric testing and field training under supervision of the [illegible].

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A health questionnaire should be sent to parents the first week of term for each family member in school.

From these questionnaires observations and anxieties of parents would be known. This together with information from teaching staff should give nurses more complete data on each child. This should considerably increase the number of early defects and illness found by nurses.

RECOMMENDATIONS

1. That information be obtained about the number of health referrals made in the various regions the nature of the defects reported and found and the effectiveness of the follow-up.

2. Since not all school principals have been through Teachers' College that all principals be fully informed about the health referral system.

3. That the Public Health Nurse follow the referral within a reasonable time so as to encourage teachers to use the system.

4. That consideration be given to the more extensive use of screening methods for the detection and correction of health defects, and that:-

(a) A regular routine program of testing visual acuity be commenced.

(b) A regular and routine program of audiometric testing be introduced.

(c) A questionnaire to mothers be used to

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(b) A regular and routine program of audiometric testing be introduced.

(c) A questionnaire to mothers be used to

supplement information available to nurses.

(d) Examination by the family physician on school entry be considered if a health care plan includes medical care for children.

(e) That the implication in increased staff to the Division of Maternal and Child Health and Public Health Nursing be considered before any attempt be made to implement these suggestions.

WORKING MOTHERS

Preamble

What percentage of Canadian women and in particular New Brunswick women are in the labor force?

What percentage of these are married women?

What percentage of these married women have children?

What child care arrangements exist in New Brunswick?

Number of married women who work

Percentage of married females in the Canadian labour force

1931.....3%

1941.....3.7%

1953.....11.8%

1960.....18.6%

Percentage of married women who remain in the home

80% of married women were not in the labour force in 1958.

It should be noted therefore that even if 50%

(d) Examination by the family physician on school entry be considered if a health care plan includes medical care for children.

(e) That the implication in increased staff to the Division of Maternal and Child Health and Public Health Nursing be considered before any attempt be made to implement these suggestions.

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Percentage of married women who remain in the home

80% of married women were not in the labour force in 1958.

It should be noted therefore that over 1/5%

of all working women were married this would not imply as is sometimes assumed that 50% of all married women are employed outside the home, as can be seen from the figure shown.

Child Care Arrangements of Working Mothers

1. Canadian

A recent survey (2) shows that of married women working in eight Canadian cities in 1956, 56% had dependent children. In 25% of these cases another relative (grandmother) was able to look after the young children.

2. U.S.A.

In March 1958 (3) 1/5 of all mothers with children under 6 years were in the labour force. It is important to remember that some of these represent one parent families. A study on the care of the young child of working mothers showed that 5.6% of young children (4) were cared for by fathers and relatives, 20% by non-relatives (neighbours etc.). 8% were expected to care for themselves.

3. New Brunswick

There is no information available on this subject in New Brunswick.

References:

1. Canadian Conference on Children. Mothers working outside the home by Margery & Kings, Phd.
2. Department of Labour, Canada - Survey of "Married Women Working for Pay" The Queen's Printer, Ottawa, 1958.

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References Cont'd:

3. David, Henry: Work, Women and Children, in the Nation's Children, Vol.3, p. 188-189. Columbia University Press 1960.

4. Department of Labour, Canada. "Women at Work in Canada". A revised fact book on the female labour force. Queen's Printer, Ottawa, 1959.

RECOMMENDATIONS

It is recommended that:-

(1) A study be made of the present methods of care of children of working mothers in the larger urban areas and that

(2) If necessary, day care centres be established for the daytime care of children for whom no other satisfactory arrangements have been made. This nursery might well provide residential care for temporary care of infants whose mothers become ill, etc. If this is not provided through government services a suitable agency should be encouraged to provide this service and this agency might well receive a government grant.

STAFFING AND HEALTH SUPERVISION

(a) It should be noted the staffing of such nurseries is a difficult matter. The National Society of Nurseries, England, has adopted the principle that the matron in charge of such a day care centre or nursery should have general nursing training together with special training in the

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nursing of sick children and preferably also public health experience.

(b) A medical officer needs to be accessible for regular inspection, supervision and advice.

(c) It is recommended that thought be given to the situation where persons in the community care for infants or preschool children in their own home in the absence of the mother. It may be wise where more than a certain number of children are cared for in one home that such homes should be registered and open to "inspection" by the Departments of Health and Welfare. There would seem to be the necessity for several systems to meet community needs, such as day care centres, daily guardians or sitters in, and boarding care by the day in private homes. It would seem necessary, however, if there are a sufficient number of children involved to foresee minimal requirements of premises and health supervision of the adults involved (mass X-ray etc.).

ILLEGITIMACY

Estimated number of illegitimate births in New Brunswick

At present there are approximately 700 per year in New Brunswick.

Comment

Results of two New York studies

Two recent studies in New York City emphasize the fact that a large percentage of the unmarried mothers

nursing of sick children and preferably also public health experience.

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studied received inadeauate prenatal medical care:-

50% did not obtain care during the first six months of pregnancy . 15-17% had no care up to the time of confinement.

When it is considered that,

1. a higher than normal percentage of these births are premature, and

2. the infant mortality rate is generally higher for such infants, adequate care for this group is important.

Application to New Brunswick

If conditions in New Brunswick were in any way comparable this would mean:-

350 mothers did not receive medical care in the first six months of pregnancy.

150 mothers would have had no care before confinement.

These studies also listed reasons why mothers did not seek aid.

In the absence of information relative to this province two recommendations are made.

RECOMMENDATIONS

1. In view of the fact that about 700 illegitimate births per year occur in New Brunswick and that we have no reason to suppose this figure will decrease, it is recommended that if a total medical care plan is not introduced that at least free prenatal medical care be made available for this section of the population. It is realized that on moral grounds this recommendation might be questioned. It is made however on behalf of the

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baby rather than the mother. If this recommendation does not meet with favour it is suggested that such care as recommended above be made available free of cost to all minor unmarried pregnant females.

2. Free natal and postnatal care be made available to all unmarried pregnant females or alternatively to all minor unmarried pregnant females.

REHABILITATION - AGE 0-19

Services under the active service program of the Division of Maternal and Child Health

I. Types of Services offered for children 0-19 yrs

1. Junior Rehabilitation Cases (Registered and accepted under this program)

(a) This includes cases previously seen under the C.C.G. program

(i) Type of case, i.e. (1) Mainly orthopedic (including post-polio, club feet, Perthes', etc.)

(2) Some E.N.T. (Cleft palate etc.)

(3) Some plastic surgery, etc.

(ii) Type of Service These were and are out-patient and in-patient services.

(b) Cases now considered under the Rehabilitation Program and not previously dealt with under C.C.G.

There has been an extension of services and a wider range of cases may now be accepted for assessment, diagnosis and treatment.

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2. Metabolic Clinic Cases

During the year small monthly Metabolic Clinics are held in Fredericton. Where necessary admissions are made to the Polio Clinic and Health Centre.

3. Paediatric Clinics

These clinics running on an experimental basis in various centres of the province during the present fiscal year are designed to supplement the "surgical" type of rehabilitation program with some "medical" type of rehabilitation by offering assessment, diagnosis and in some instances treatment (including drug therapy) for special categories of cases in patients whose families cannot afford this care. All the paediatricians in the province cooperate in this program.

SUMMARY

1. Rehabilitation cases 2. Cases for Metabolic Clinics 3. Paediatric Clinics

II. Case finding, referral and registration - Continuous Sources

1. Newborn

Reported by Physicians on the Physician's Notices of Birth forms.

2. Infant, Children and Young Persons - generally directly from doctors.

(iii) Type of Service: These are out-patient and in-patient services

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3. Occasional Sources

1. Direct requests from public (re-routed back through Public Health Nurse and family doctor before being considered).
2. Referrals from other Departments and/or Divisions, i.e. Department of Youth and Welfare.
3. D.V.A.

III General

During the last fiscal year a continuous effort has been made to distinguish between cases registered with the Division for information and not for service and those registered for both.

Those for whom a specific service is requested are considered as being on the Active Service Program. Those on the Active Service Program (by far the highest percentage) + those registered for information only = Register of Handicapped Children and Young Persons.

IV. Increase in register of Handicapped Children and Young Persons

	New Cases Registered	Total Number on Register
1956	138	542
1957	542	1915
1958	1199	3114
1959	886	4000-(3288 under active
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Increase in one of Services, i.e.: - Polio Clinic and Health Centre

	In-Patients	Out-Patients	Total
1956	110	182	293
1957	148	321	469
1958	97	870	967
1959	283	871	1154
1960	442	1584	2026

V. Active, Inactive and Completed Cases

Cases are constantly moving on and off the Active Service Program and register or into different categories. Certain disabilities may as a result of surgery have been treated and cannot recur (i.e. removal of supernumerary digitis, etc.). Those cases are then considered completed. However, if a case will probably require future review in a period of time longer than one year the condition may be considered inactive and be so recorded (i.e. repair of cleft palate for whom it is predicted orthodontic work will later be required), cases may be transferred to other services, move out of the province or die. A regular review of cases assists in co-ordinating services and follow-up of cases.

VI. Number of Cases Assisted

Due to changes over last year from C.C.G. to Rehabilitation with its resultant increase in number of new cases assisted, together with cases for whom new assessment or group services were given or considered, the total number of cases receiving attention increased.

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New Cases of Rehabilitation

General	1083
Post Polio	36
Mentally retarded	469
	1588

Active Service Register and Mentally Retarded - March 13, 1961

This register consisted on March 31, 1961 of 4013 Active Service Cases + 1941 mentally retarded for whom some service was being rendered or considered + 289 other cases which were treated and became inactive :- 6 who refused treatment suggested by doctor + 7 suspended from program because income too high = 6356 cases 6356

Handicapped Children and Young Persons not included in above.....879

Therefore, total number on Handicapped Register.....7235

During the Year

1. Number of cases transferred to Rehabilitation Division.....225 (and not included in the totals above as they were ready for transfer on April 1st, 1960 following the annual review of cases. They were transferred before this fiscal year really got under way)

2. Number of cases referred to the Co-ordinating Council.....88 (2 died)

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3. Audiometric program

(1) Number of hearing assessments done by E.N.T. Specialist.....61

(2) Number of hearing aids bought.....29

A number of individual audiometric assessments were also done by a member of the Division at the Polio Blinic and Health Centre by a request of a family Physician or specialist.

Supplying of Orthopedic appliances, hearing aids, glasses, etc. Present position and suggestions for the future

A. Orthopaedic Appliances

Present Position

In the fiscal year 1960-61 $30,000. was spent on supplying orthopedic appliances to children and young persons receiving assistance through the Junior Rehabilitation program. This includes most appliances "attached" to the person but does not include wheelchairs which are usually supplied in cases of need through the Co-ordinating Council for the Handicapped.

Future

If a total care plan is not introduced and present rehabilitation services are to be extended it would be fairly easy to calculate the amount required depending on the expected new number of persons to the service. However, the present system of buying service from private firms is a very expensive one. Prices vary widely between different suppliers.

(1) It is strongly recommended therefore, that

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(2) If it is possible to avoid buying from private dealers one government orthopedic workshop should be established so that costing might be controlled, together with quality of material supplied and if there is not a total care plan introduced and rehabilitation services continue as at present, that patients on our service receive attention and their appliances within a reasonable time.

(3) These services should be supplemented by small orthopedic workshops in the main hospitals where technicians could deal with simple matters for in and out-patients, such as heel wedges, brace adjustments, etc.

B. Hearing Aids

Present System

Hearing aids are provided to patients in need under the present Junior Rehabilitation plan. In the last fiscal year 29 were supplied. These remain the property of the government, parents signing that they appreciate that these are on loan, not to be sold or exchanged and removed if not in use.

Future

Advise continue as at present. Supplying hearing aids only as a result of means test.

C. Glasses

Present System

These are at present bought for those in need

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C. Glasses

Present System

These are at present bought for those in need

by service clubs. Through Junior Rehabilitation program visual assessments are paid for through government grants but glasses are bought by patients or voluntary groups.

Future

Advise continuing as at present.

Orthopedic Workshops

See introduction.

Rehabilitation Centres

Comments

At present the Rehabilitation Centre in Fredericton, together with beds at the Polio Clinic and Health Centre, are expected to serve the needs of New Brunswick.

It seems evident that this is not or cannot be so. A second Rehabilitation Centre is needed in the French-speaking area, and this, probably, in the interests of staff economy and so as not to duplicate equipment should be a combined institution for childrenand adults with separate wings for children and young persons.

It is probable that details on this subject have been provided by the Director of Rehabilitation Division, Mr. G.W. Crandlemire.

Accidents

It would seem definite that accidents will continue to be an important cause of mortality and morbidity in the age group from birth to 19 and that inevitably Departments of Public Health will be involved in accident prevention or safety programs. These programs will inevitably require studies of the epidemiology of

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RECOMMENDATIONS

(1) That staff be provided in the Maternal and Child Health Department (viz at present one nurse to be sent away for special training) to develop a home safety program and to help to co-ordinate activities in this field.

(2) As a part of this work all accidents leading to hospitalization, excluding those concerned with traffic, fire, drowning, be followed up by a Public Health Nurse and reports sent to the Maternal and Child Health Division.

(3) Poison Control and Poison Information Centres be properly developed and spaced in the province.

NOTE ON OCCUPATIONAL HEALTH SERVICES

Adolescents and Potential Mothers in Industry

The number of adolescents employed in industry together with the larger number of potential mothers should not pass without notice. From this point of view it is interesting to note that the B.M.A. thinks that

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"Statutory responsibility for occupational health services should be vested in a government department advised by central occupational health services council. This would lay down standards and would be responsible for overall planning. There should be regional councils with one or more administrative officers with a wide experience of industry. The regional councils would coordinate services and ensure collaboration with the industries and the universities". Quoted from the British Medical Journal of July 1, 1961, Page 38.

Recommended

That study be given to the health supervision and care of adolescents in training and in industry.

NUTRITION

General

State of present knowledge in Public Health Work

A good basic program of nutrition education has existed in this province for many years.

Nutrition knowledge is still in its infancy in regard to certain types of public health work. Developmental nutrition which considers intake over a life span in the society where limitation of food is not a problem is a field which will, in the future, require attention. The need for longitudinal studies is obvious but will be done in the near future and knowledge again will inevitably need application.

Staff - General Comments

Periodic shortage of well trained staff has

vices should be vested in a government department advised by central occupational health services council. This would lay down standards and would be responsible for overall planning. There should be regional councils with one or more administrative officers with a wide experience of industry. The regional councils would co-ordinate services and ensure collaboration with the industries and the universities". Quoted from the British Medical Journal of July 1, 1951, page 38.

Recommended

That study be given to the health supervision and care of adolescents in training and in industry.

NUTRITION

General

State of present knowledge in Public Health

A good basic program of nutrition education has existed in this province for many years.

Nutrition knowledge is still in its infancy in regard to certain types of public health work. Developmental nutrition which considers intake over a life span in the society where limitation of food is not a problem is a field which will, in the future, require attention. The need for longitudinal studies is obvious but will be done in the near future and knowledge again will inevitably need application.

Staff - General Comments

Periodic shortage of well trained staff has

been experienced in New Brunswick. This seems to be part of a wider national and international shortage.

"A Joint F.A.C.-W.H.O. Expert Committee on Nutrition met in Geneva from the 18th to the 25th of April, 1961 to review progress in the nutrition work of the two organizations since 1957, examined current activities in this field and advise on future programs....".

"The shortage of suitably trained workers has been one of the drawbacks to the nutrition programs in many parts of the world. F.A.O. and W.H.O. have tried to help overcome this shortage by organizing training courses and providing fellowships for training abroad. In recent years, U.N.I.C.E.F. has allocated funds for assistance in this field, mainly in connection with its program of expanded aid to Maternal and Child Nutrition".1

Public Health Staff - Nutritionists and Dietitians, Department of Health

1. Maternal and Child Health Division

   The plan of organization of this Division provides for five nutritionists and/or dietitians.

2. Hospital Services

   This Division has on its staff a Consultant Dietitian.

NOTE

Development of Health Care Plans

As medical care programs develop more dietitians and public health nutritionists will be needed.

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2. Hospital Services

This Division has on its staff a Consultant Dietitian.

Development of Health Care Plans

As medical care programs develop more dietitians and public health nutritionists will be needed.

It is recommended, therefore, that:-

A more vigorous recruitment and training program be undertaken. The present system of bursaries following graduation is not bringing sufficient staff to the field. It is strongly urged that buraaries be given for the last two years of the Bachelor Degree in Home Economics.

SECTION G

MEDICAL REHABILITATION SERVICES

1. Rehabilitation services in New Brunswick are provided, in the main, at two hospitals with a moderate volume provided in other active treatment hospitals, including the Department of Veterans' Affairs Hospital at Lancaster owned and operated by the Government of Canada. The Polio Clinic and Health Centre provides facilities for children with various disabilities and for adults with disabilities due to poliomyelitis. The Forest Hill Rehabilitation Centre provides facilities for adults with all types of disabilities. The Polio Clinic and Health Centre has a rated capacity of 79 beds with a completely equipped service for all types of therapy relative to rehabilitation, as well as extensive out-patient facilities in this service. Forest Hill Rehabilitation Centre has a rated capacity of 20 beds with all modern facilities for therapy and extensive out-patient facilities for this special service. Both of the above institutions are approved and operate as active treatment hospitals under the Hospital Service Plan.

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2. The Medical Rehabilitation Program in the Province at the present time includes all age groups in the population. Age 0-19 years in one group and 19 years and over in another group. Hospital services are provided to both groups under the Hospital Service Plan and physiotherapy out-patient is an entitled service under the Plan. Physical and financial assessment is carried out on all cases of disability who desire to avail themselves of additional services provided by provincial government funds. At the present time, additional services are not provided to any cases that are found to be able financially to provide such service on his own behalf. The additional service provided by the Department of Health includes medical assessment, medical and surgical services, prosthetic appliances and other medical aids and assistance for the patient who must live away from home while receiving out-patient physiotherapy. This service to disabled individuals was provided in 1960 at a cost of $137,000.00 exclusive of hospital services. In addition the administrative co-ordination of rehabilitation cost $40,000.00. Both these expenditures were claimed 50% from federal funds and the remaining 50% was provided from provincial funds.

STATISTICS FOR YEAR 1960

New cases referred.....371

Cases on file.....2352

Assessment Services (Medical Vocational, Social).....1778

Medical Treatment (Number of Persons treated).....254

Trained.....183

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STATISTICS FOR YEAR 1960

Cases on file.....2372

Medical Treatment (Number of Persons

Social).....1,[illegible]

Counselling Services.....1520

Rehabilitated to Employment.....277

Those who have been rehabilitated to employment had a total of 259 dependents and were costing the province, the municipality, or their relatives, a total of $154,000.00 per year to maintain them. After rehabilitation, their combined yearly salaries amounted to over $487,000.00 and they became contributing members to society. The problem involved in rehabilitation of the disabled in this province remains a formidable one. The program has been in operation for a period of eight years with a consistent expansion annually. In this period there has been 1,800 adult disabled persons rehabilitated, while 1,200 disabled adults are registered but have not yet received rehabilitation services. In addition, it is estimated that there are approvimately 5,000 disabled persons of all categories in our population who require some degree of rehabilitation services.

3. From the foregoing paragraph it is evident that additional facilities in this phase of health care are required. Estimates of requirements and costs are as follows:

(a) Expansion of Forest Hill Rehabilitation Centre by the addition of 40 beds. Estimated cost at $4,000.00 per bed. Then 40 x $5,000.00 = $200,000.00.

(b) Construction of a new 60 bed rehabilitation centre in the north of the province. Estimated at $8,000.00 per bed, with appropriate outpatient facilities. Then 60 x $8,000.00 =

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(b) Construction of a new 60 bed rehabilitation centre in the north of the province. Estimated at $8,000.00 per bed, with appropriate out-patient facilities. Then 60 x $8,000.00 =

$480,000.00.

(c) Train or procure a specialist in physical medicine to service the northern area of the province.

(d) Train at least 8 physiotherapists annually for the next 5 years. Estimated annual cost, $20,000.00.

(e) Establish physiotherapy facilities at 8 additional general hospitals in the north and east of the province where no such facilities exist at the present time. Establishment of these general hospital centres is estimated at $10,000.00 each for equipment, or a total of $80,000.00.

(f) Provide a mobile assessment clinic, thus making it possible to provide assessment service to disabled residents of the province without requiring them to travel long distances to see a specialist for diagnostic purposes. Estimated cost of such a service would be $25,000.00 annually. The expenditures related to the services above may be provided on a matching basis with the federal and provincial governments each contributing 50% of the costs. This applies to all expansion except hospital construction where the federal government will contrivute a maximum of $2,000.00 per bed.

4. There exists a grave deficiency in the number of trained physiotherapists in the Province at the present time. With the extension of services suggested in the foregoing paragraph, it is estimated we would require a

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There exists a grave deficiency in the number of trained physiotherapists in the Province at the present time. With the exception of services suggested in the foregoing paragraph, it is estimated we would require a

total of 58 trained workers of this type. At the present time, there are 19 trained physiotherapists employed in the province. It is estimated then we would require an additional 39 trained individuals by 1965 to provide an adequate service in rehabilitation of our disabled people.

SECTION H

CANCER CONTROL SERVICES

1. The cancer services have recently been revised and expanded effective March 1, 1961. Previous to that date, the province was providing a diagnostic service at six diagnostic clinics in the province, uninsured laboratory and X-ray out-patient diagnostic service, facilities for biopsy service and all types of out-patient radiotherapy for cancer treatment. When residents of the province are treated in active treatment general hospitals for proven cases of malignant neoplasm, they become eligible to have their medical surgical, anaesthetic and consultant fees paid for under this program during the period that they are patients in active treatment hospitals.

2. This extension of services applied only to patients treated in hospital and does not include the payment of the surgeon's or physician's fee for any out-patient services. In addition to the payment of the physician's and surgeon's fees, those of the anaesthetist and assistant surgeon are paid for and where consultant services are required by the surgeon, the consultant's fee also may be paid for. The diagnosis of malignant

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neoplasm must be confirmed by a Histopathological report but in cases of doubt of the diagnosis such cases will be referred to the Clinical Advisory Committee of the Division of Cancer Control. When appropriate treatment is not available by qualified personnel in New Brunswick, such treatment will be paid for as an out-of-province benefit but only if prior permission has been given by the Minister of Health. Remuneration is made to practitioners for professional services rendered, according to the New Brunswick Medical Society Minimum Schedule of Fees, 1956, as amended, less five per cent. In addition to the extension of services as noted above, the Cancer Control Program pays for, as formerly, out-patient radiation therapy, out-patient diagnostic X-rays and uninsured out-patient laboratory procedures required for the diagnosis of cancer, upon reference through the Cancer Diagnostic Clinic by the attending physician. Since in-patient hospitalization, in-patient radiation therapy and in-patient diagnostic procedures, both laboratory and X-ray, together with certain approved out-patient laboratory procedures, are insured services. These are provided as any other insured service by the Hospital Services Division of the Department of Health of the province.

3. There is an averageof 500 new cases of malignant neoplasm occurring annually in the population of New Brunswick over the past five years. Treatment is provided at four centres, with cobalt therapy and isotope facilities available at one of these centres. The volume of treatment provided at these centres is set forth as

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follows:

	Laboratory Units	X-Ray Units	No. of X-Rays
Saint John General	9483	11161	387
Moncton Hospital	1874	10819	252
Victoria Public	7762	9025	257
St. Joseph's Hospital	1933	1476	67
TOTALS	21052	32481	963

	Out-Patient Therapy Units	No. of Treatments
Saint John General	62392	2877
Moncton Hospital	25289	1092
Victoria Hospital	8910	418
St. Joseph's Hospital	4012	264
TOTALS	100603	4651

The estimated cost of providing this service from public funds for the year of 1961 is $250,000.00. Fifty percent of this expenditure is claimed from National Health Grants and the remaining fifty percent is provided from provincial funds. The program has been highly satisfactory, both to the providers of the service (the medical profession) and to the receivers of the service, the people of New Brunswick.

SECTION I

DENTAL HEALTH

An estimate of the quantity and cost of dental treatment presently being received by the population of New

follows:

	Laboratory Units	X-Ray Units	No. of X-Rays
Saint John General			
Moncton General			
Victoria Public	7762	9029	297
St. Joseph's Hospital	1933	[illegible]	[illegible]
TOTAL			

	Out-Patient Therapy Units	No. of Treatments
Saint John General		
Moncton Hospital	25289	1092
Victoria Hospital	8920	[illegible]
St. Joseph's Hospital	4012	2[illegible]
TOTALS	100603	[illegible]

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SECTION 1

DENTAL HEALTH

An estimate of the quantity and cost of dental treatment presently being received by the population of New

Brunswick annually

Quantity - The latest survey of Canadian Dentistry carried out by the Canadian Dental Association in 1958 shows that Canadian dentists saw an average of 1000 patients in a year. The averages by provinces ranged from 429 to 1378. The dentists of New Brunswick saw the second highest number of patients per dentist of any Canadian province, namely 1169. On this basis, over 133,000 different dental patients are treated annually in this province. 22% or roughly one-fifth of the population is receiving dental treatment annually. The New Brunswick Health Survey of 1951 showed that 10 years ago, no more than 10% of the children were receiving all the dental treatment they required. Recent figures indicate little if any change.

Summary Approximately 20% of the population receive dental care annually.

Costs - Taxation statistics published in 1960 show by a samplying method that the total net income of all dentists in New Brunswick for the year of 1958, amounted to $944,000.00. It is further estimated that the gross income for that year was $1,575,000.00. From this it is noted that the overhead related to operation was 40% of the gross. Projecting these costs to 1961, the gross cost will be approximately $1,670,000.00 and the net cost will be $1,670,000.00 less 40% overhead which equals a net cost of $1,000,000.00 for the year of 1961. If a comprehensive plan were instituted for the dental care of our population, excluding 50% of the cost of artificial dentures, the cost would increase by 20%

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the first year of operation or to an estimated $2,000,000.00.

Second year of plan	$2,200,000.00
Third year of plan	$2,420,000.00
Fourth year of plan	$2,660,000.00
Fifth year of plan	$2,920,000.00

The estimated increase under a comprehensive plan excluding 50% of the cost of artificial dentures, as a deterrent, would increase 20% during the first year and an average of 10% for the succeeding four years. After five years of operation, it is reasonable to assume that the costs will have leveled off to an annual cost of $3,000,000.00.

Additional costs of extended services are estimated as follows:

Operation of 25 proposed school dental clinics staffed by a dentist and dental assistant at $15,000.00 each, $375,000.00.

Operation of 15 public clinics throughout the province at an estimated $15,000.00 each annually or a total of $225,000.00.

This would result in an estimated cost annually after five years of operation, at approximately $3,600,000.00 or an estimated per capita cost of $5.45 on an estimated population of 660,000 in the year of 1965.

The balance of costs, not included in dental income, for school clinics in Moncton and Saint John, mental and tuberculosis hospitals etc., is estimated at $65,000.00. Illegal practice is estimated at 5% of gross

[illegible]

000.00.

Second year of plan	$2,200,000.00
Third year of plan	$2,490,000.00
Fourth year of plan	$2,[illegible]
Fifth year of plan	[illegible]

The estimate [illegible]

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Additional costs of extended services are estimated as follows:

Operation of 25 proposed school dental surgeries staffed by a dentist and dental assistant at $[illegible] [illegible]

Operation of 15 public clinics throughout the province at an estimated $15,000.00 each annually or a total of $225,000.00.

This would result in an estimated cost annually after five years of operation, at approximately $3,000,000.00 or an estimated per capita cost of $4.[illegible] on an estimated population of 650,000 in the year of [illegible]

The balance of costs, not included in dental income, for school clinics in Moncton and Saint John, mental and tuberculosis hospitals etc., is estimated at $[illegible],000.00. Illegal practice is estimated at [illegible]% of gross

dental income or $100,000.00. Various other costs are also estimated and include welfare funds, service club contributions, individual dental charity, etc.

The following are not included -

1. Department of Veterans' Affairs in hospital dental costs.
2. Armed forces dental costs.
3. Dentistry provided for Indians by salaried dentists.
4. Dental costs in Federal prisons.

Summary In our opinion, $1,700,000.00 represents a fair appraisal of the total cost of all dental care presently provided annually to residents of New Brunswick with the four exclusions above.

The existing facilities and methods of providing dental health services in New Brunswick

114 dentists practice in the province in approximately 110 dental offices, which are in effect the dental hospitals and dental surgeries of the province.

The provincial government provides free dental care to patients in two mental hospitals and four tuberculosis hospitals.

The provincial government assists the Saint John County Board of Health and Moncton City in providing dental care for needy school children.

The federal government provides dental care for a number of veterans through the Department of Veterans' Affairs and also provides dental service for Indians and sick mariners through the Department of

total income or $100,000.00. Various other costs are contributions, individual dental charity, etc.

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1. Department of Veterans' Affairs in hospital [illegible]

2. Armed forces dental costs.

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The federal government provides dental care for a number of veterans through the Department of Veterans' Affairs and also provides dental service for Indians and sick mariners through the Department of

National Health and Welfare.

One general hospital provides an out-patient dental service.

Orphanages receive dental care and jails and other custodial institutions provide some emergency dental service.

Personnel

Dentists - The attached Table (I) shows the population per dentist by provinces. New Brunswick has one dentist for every 5,175 persons compared with a national average for Canada of 1:3018 and ranks next to Newfoundland as being in the worst situation in this regard. Yet on a provincial basis it would be difficult to prove or disprove that, under the present social system, more dentists are required. This statement requires explanation.

The need for much more dental treatment is obvious but the demand for such treatment is depressed by two factors - the lack of appreciation of the importance of dental health and the lack of means. Too frequently it is assumed that, if the limitations of cost and availability of services were eliminated, demand would at once equal need. Both experience and common sense indicate that this is not so. Among indigents in certain areas, where dental services are readily available without charge, the rate of utilization is always far below need if no special health education program is undertaken. Similarly, among the upper income group, where the cost of dental care is not a limiting factor, the demand for care may still be considerably below need.

National Health and Welfare.

One general hospital provides an out-patient [illegible]

Orphanages receive dental care and jails and other custodial institutions provide some emergency [illegible]

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Attached is a Table (III) comparing the population per dentist with incomes per capita by provinces which gives a good correlation of the effect of economics on the number of dentists a province can support. Because this situation has persisted over the years, obviously the backlog of unmet needs is greater in New Brunswick than in most other provinces, compounding our problems. It is believed that this province could support perhaps 6 additional dentists in private practice at the present time. Any further expansion would depend on an improvement in the economic situation or financial aid.

Dental Technicians

These were first established by dentists to process appliances to their order. As economics gradually brought changes, it was found to be advisable and better business for technicians to work for groups of dentists and direct communication with one or more individual dentists became less common. Eventually dental technicians established self contained businesses. They have improved their services and the public have benefited. They are a useful and necessary part of the dental team. Few, if any, courses of training are available. Standards of qualifications are lacking. They are dependent entirely on the dental profession for income. Falling economics and lack of standards has caused havoc at times and they are subject to all the perils of other small businesses. There are presently 30 dental technicians in this province. We appear to

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[illegible] 80 dental technicians in this province. We appear to

have sufficient dental technicians but they are concerned with the threat to the trade of increasing age and lack of recruits.

Dental Assistants

About 75% of the dental profession employ dental assistants often loosely termed dental nurses. They are apprenticed trained and are not an organized group. They perform a useful function and divide their time between chair side assisting, bookkeeping, reception of patients, etc.

Dental Hygienists

This province formerly employed two dental hygienists. Two more are in training. This training consists of a two year university diploma course. They are employed mainly in dental health education in schools through routine dental inspections and prophylaxis.

The Improvement of Dental Health Services

Dentistry is not an adjunct but an organic part of health. In order that the "best health care" is available to all calls for consideration of the key factors that depress the present public demand for regular dental care - the lack of appreciation of the importance of dental health and the lack of means. The first is a matter of education and the second a problem of cold economics. Without the removal of the barrier of economics, education can only urge a redistribution of expenditure of existing income. If a well administered budget cannot extend to health care, no amount of

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Dentistry is not an adjunct but an organic part of health. In order that the "best health care" is available to all calls for consideration of the key factors that depress the present public demand for regular dental care - the lack of appreciation of the importance of dental health and the lack of means. The first is a matter of education and the second a problem of cold economics. Without the removal of the barriers of economics, education can only urge a redistribution of expenditure of existing income. If a well administered budget cannot extend to health care, no amount of

education can provide dental treatment.

We are therefore brought to the conclusion that the best dental care for the citizens of New Brunswick can only be obtained by the establishment of a comprehensive service which may never be wholly adequate but which is equally available to all who demand it and which will be paid for by the community as a whole.

Health care should be divorced from the question of personal means and if there are shortages of services, the shortages should be shared by all.

We return to the question - how can we "ensure that the best possible health care is available" to the citizens of New Brunswick? From the standpoint of dentistry in this province, we can come to no other conclusion than that stated above.

A comprehensive dental care program could be planned independently. It is doubted that the public would accept a separate plan for dentistry or in fact for any other division of health care.

The introduction of a comprehensive dental care plan for dentistry or in fact for any other division of health care.

The introduction of a comprehensive dental care plan as part of a complete health care plan and at the same time as a medical care plan would have the best chance of success and is therefore recommended.

Necessary preliminaries to the introduction of a comprehensive public financed dental care plan

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The introduction of a comprehensive dental care plan as part of a complete health care plan and at the same time as a medical care plan would seem the best chance of success and is therefore recommended.

Necessary preparation to the introduction of a comprehensive public financed dental care plan

Great Britain has had a comprehensive dental care plan for over ten years. Direct comparison with the situation there would not be valid. On the other hand, much useful information is available.

Before the commencement of the health scheme in Great Britain, about 10% of the profession were already employed full time in a school dental service. Priorities were established for expectant and nursing mothers and adolescent children.

On the commencement of the British Health Plan, demand exceeded supply by a much wider margin than anticipated.

Many dentists left the school dental service for the general dental service. The opposite of what was planned occurred. There was an over-whelming volume of dentures. In 1950, one-third of patients treated were supplied with dentures (about 3 million out of 9½ million at a cost of over 60% of total cost of the dental service at that time. Few hospitals could offer consultant dental service of treatment. The British commenced on the understanding that there was inadequate dental manpower to provide a comprehensive dental service but the shortage was much greater than expected.

Using British experience as a useful aid but not as a guide, it would seem advisable to have no priorities when the plan is inaugurated.

Three areas should be provided for before the commencement of a comprehensive plan and they are - (1) the establishment of a school dental service. (2) the establishment of a hospital dental service.

[illegible]

[illegible]

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Using British experience as a basis, six [illegible] cities where the plan is implemented.

These areas should be provide for before the commencement of a comprehensive plan and they are - [illegible]

the establishment of a hospital dental service.

(3) a controlled, but not a free system to provide dentures for these requiring them.

School Dental Service

The building up of a group of salaried dentists to provide dental care exclusively for school children would appear to be the most practical method to build in a priority for the dental care of children. Using regional schools as basic units, we would eventually require at least 60 dentists for such service. Pre-school children would also be eligible to take advantage of this service. The equivalent of at least 25 dentists should be available at the commencement of the plan.

Hospital Dental Service

Dentists trained in oral surgery, particularly in the treatment of fractures of the jaw, should be recruited and arrangements made for them to be full time staff members in the large general hospitals providing dental service as required and consultation to small satellite hospitals. It is estimated that 6 such dentists would be required. The equivalent of 2 dentists so trained should be available at the commencement of the plan.

The denture problem

In an area of low economics, dental treatment is neglected, extractions and dentures are common and tend to become so accepted as commonplace, that dentistry meand to a large proportion, merely extraction of

(3) a controlled, but not a free system to provide dentures.

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The dental care plan

[illegible] is neglected, extractions and dentures are common and [illegible] lately meant to a large proportion. Merely extractions at

teeth and replacement.

In the event of the inauguration of any comprehensive dental scheme without financial barriers, the floodgates will open a terrific demand for dentures in any area.

From our experience, the private dental practice and the veterans' dental administration in New Brunswick, indicates that the demand for dentures in this province will be even higher than most other areas. Consequently, it appears obvious, at least to us, that we cannot completely remove the economic barrier in so far as dentures are concerned. The experience in Great Britain, for instance, was such that, after less than two years of a free plan, charges for dentures had to be introduced and after thirteen years of the plan, now amount to about 50% of the total fee.

Whether a decision is made to exclude the cost of dentures from any scheme or to include them to some degree, a study of the economic factors involved in the provision of dentures is considered necessary.

Approach should be made to the dental profession and the organized technicians, to consider this problem, in an effort to reduce the cost of standard dentures, before any decision is arrived at, regarding their inclusion or otherwise in any plan.

Number of dentists required

The implementation of a comprehensive dental service depends on sufficient dental manpower to take care of a demand, the exact extent of which can only be

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Whether a decision is made to exclude the cost of dentures from any scheme or to include them to some degree, a study of the economic factors involved in the provision of dentures is considered necessary.

Approach should be made to the dental profession and the organized technicians, to consider this problem, in an effort to reduce the cost of essential dentures, before any decision is arrived at regarding their inclusion or otherwise in any plan.

Number of dentists required

The implementation of a comprehensive dental service depends on sufficient dental manpower to meet the demand, the exact extent of which can only be

estimated. The inherent problem is of two kinds - (1) to anticipate the probable demand for treatment and (2) to estimate the likely incidence of the various forms of treatment.

Under the existing social system, demand is related directly to economic means. It has been estimated that 6 more dentists could make a satisfactory living in this province.

Under the proposed system where the economic barrier is removed, the best estimate of demand is that a minimum of about 25 additional dentists are required to begin a comprehensive service and that the need will rise eventually to a total of about 90 additional dentists or a total registration of about 200 dentists.

Methods for more rapidly increasing dental manpower

1. Accelerated or crash courses as carried out during two world wars.
2. Reduction of the length of the course by other methods.
3. The use of dental auxiliaries.
4. Change in licensing acts.

Interprovincial movement and/or immigration of dentists

If we cannot produce enough dentists or the time required to produce them is considered too long, then we must turn to auxiliaries. If the profession and the public are prepared to accept such auxiliaries, then they could be available in reasonable numbers within five years.

Two possible fields would be operative

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technicians for children's dentistry and/or the provision of dentures. Dental nurses of the New Zealand type are examples of auxiliaries for children's dentistry. Properly trained technicians for intra-oral prosthetic work are not yet a reality but were recommended and their scope outlined in the Paynter Report to the University of Manitoba.

These alternatives are mentioned but not recommended at this time. The gravity of the present problem both as a threat to public health and as a threat to the solidarity and even future of the dental profession is not fully realized. If steps to provide a rapid and substantial increase in the number of dentists are not taken, at the earliest possible moment, less attractive alternatives must be implemented.

There is considerable disparity between the salaries of dentists in different provinces. In the fact of anticipated shortages, it will be impossible for this province to attract more dentists unless they can offer higher salaries than others or until there is some national standardization in salary levels.

In the absence of an equalization formula, the situation will get progressively worse, in those provinces with lower financial ability. (Table III).

Dental Recruitment

The Regular Officers' Training Plan of the armed forces, which has been recently improved, has been a powerful stimulus in recruiting dentists for the armed forces. This is paid for out of the National Defence

[illegible] as examples. Dental nurses of the New Zealand type are examples of auxiliaries for undeveloped departments. Properly trained technicians for intra-oral prosthetic work are not yet a reality but were recommended and their scope outlined in the Joyner Report to the University of Manitoba.

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Dental Requirement

The Regular Officers' Training Plan of the [illegible] Forces, which has been recently improved, has [illegible]

Budget. No one can deny its value or necessity but is it not equally important to provide scholarship aid for dentists for the general public? The Budget of the Department of National Health and Welfare should provide a similar plan for dentists for general dental services. However, to avoid difficulties, would it not be advisable to make similar benefits available for women only?

Dentistry as a Career for Women

Some girls and parents have rejected dentistry as a career on the ground that they were sure they lacked the physical strength which they believed to be necessary. This impression is entirely erroneous.

On the contrary, women have certain qualities which appear to make them eminently suitable members of the dental profession. They have a natural aptitude for any healing art and most of them have a gift for the handling of children which is particularly useful in the dental profession. There is one other relevant factor that should be mentioned. Opportunities for part-time work are numerous in dentistry so that it is easier for married women whose whole time is not being required for their domestic duties, to engage in the part-time practice of their profession and thus make a substantial contribution to the needs of the country. It is for these reasons that women are playing so valuable a part in the school and general dental service of other countries as shown in the attached Table IV.

Because dentistry appears to us to be parti-

[illegible] necessary but it is not equally important to provide scholarship aid to dentists for the general public. The budget of the Department of National Health and Welfare should provide a similar plan for dentists for general dental services. However, to avoid difficulties, could it not be advisable to make similar benefits available for women only?

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Because dentistry appears to be [illegible]

cularly suitable as a profession for women, whether married or single, we recommend that the authorities responsible for publicity, take every step to ensure that girls, girls' schools and parents are fully aware not only of the need to enlist women in the ranks of the profession but of the positive advantages which for them, dentistry has over many other professions.

Financial aid to students

At present there is a sharp national upturn by many agencies and levels of government in providing financial assistance to worthy university students. This is a highly commendable action and no doubt will increase.

Insofar as the spending of public funds is concerned, not enough attention is given to the relative public need for men and women of various professions. There must be a direct connection between the anticipated demand for personnel in specific fields and the expenditure of public funds for student aid.

When the situation is reviewed in this light, a very high priority indeed would be attached to dental training.

Student Assistance

It is proposed that the province, with the assistance of federal health grants, subsidize dental students in a somewhat similar manner as the Regular Officers' Training Plan of the Department of National Defence and with a similar provise that they accept employment with the province concerned and in the locations

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Student Assistance:

It is proposed that two programs, with the [illegible] students in a somewhat similar manner as the Regular Officers' Training Plan of the Department of National Defence and with a similar proviso that they accept [illegible]

specified for a certain minimum number of years. The annual benefits while training should be less, the guaranteed salary in the school dental service should be higher than beginning army pay and permission to do adult dentistry after school hours should be permitted and encouraged.

It is suggested that student assistance while training should be in the order of $2,500.00 per student per year. Beginning salaries in school dental service should be in the $8,000.00 range.

Problems peculiar to dentistry

1. In a consideration of dental care under the headings of prevention, diagnosis, treatment and rehabilitation, it must be remembered that the vast majority of dental care and dental treatment is in fact, rehabilitation. Diagnosis, treatment and rehabilitation and a certain amount of prevention are all functions of the dentist carried out normally in his office or dental hospital.

The prevention of dental disease depends on oral hygiene, diet, the use of fluorine and regular dental care. In few, if any, other health areas, is the personal motivation and co-operation of the individual of such prime importance, as in the field of dental health. It is in this field of individual action that the public health dentist and all public health workers and teachers have a large responsibility.

2. From a general health standpoint, national attention is being directed to medical care with the

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health workers and teachers have a large responsibility.

2. From a general health standpoint, medical attention is being directed to medical care with the

generally accepted thought that hospital care has been insured and assured on a national basis. This is not true from the standpoint of dental health.

The dental hospitals are the offices of private practitioners and clinics. Insofar as the former are concerned and they are vastly in the majority, the entire cost is borne by the dentists and obviously must be recovered in fees. It is generally accepted that dental overhead averages 50%, which simply means that in private practice, public dental costs are double the net income of the profession.

The desirable relation between the dental profession and the public

1 It should be based on the principle that dental service is equally available to all and not compulsorily imposed upon any.

2. The dentist must be free to engage whole or part-time in either public service or private practice.

3. The patient must have free choice of a dentist and the liberty to alter his choice if he so desires.

4. The patient must have the free right to seek dental care by private arrangement and private fee if he so desires.

Note

1. Recruiting graduate dentists at higher salaries would eliminate training and subsidization costs.

2. Dental clinics on school grounds could be combined with other health services if required at a reduction in total capital expenditure.

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Note

1. Recruiting graduate dentists at higher salaries would eliminate training and rehabilitation costs.

2. Dental clinics or school services could be combined with urban health services if worked at a reduction

I

Dentists Practicing in Canada 1960

Province	Total	* Total Related to 1938	** Ratio to Population
Nfld.	43	+24	1/10,441
N.B.	114	+ 4	1/5, 175
Sask.	192	-18	1/4, 698
N.S.	193	+24	1/3, 710
P.Q.	1384	+510	1/3, 612
Man.	277	+26	1/3, 195
Alta.	412	+176	1/3, 017
P.E.I.	35	+5	1/2, 914
B.C.	653	+291	1/2, 404
Ont.	2477	+545	1/2, 403
CANADA	5780	+1587	1/3, 018

* These figures show the increase or decrease in number of dentists today compared with 1938.

** Based on estimated population figures as of June 1, 1959, provided by Dominion Bureau of Statistics.

Province	Total	Increased by 1936	Ratio to 1936
N.B.	114	+4	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
N.S.	143	+24	[illegible]
P.Q.	1384	+310	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
P.E.I.	35	+5	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Ont.	2471	+341	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
CANADA	5780	+1347	[illegible]

* These figures show the increase in certified in number of sanitaria today compared with 1936

** Based on estimated population figures as of June 1, 1939, provided by Dominion Bureau of Statistics.

II

Population per dentist compared with Income per person by Provinces - 1960

Income per person in ascending order of magnitude		Population per dentist in descending order of magnitude	
Newfoundland	$856.00	Newfoundland	1: 10,441
Prince Edward Island		New Brunswick	
New Brunswick		Saskatchewan	
Nova Scotia		Nova Scotia	
Quebec		Quebec	
Saskatchewan		Manitoba	
Manitoba		Alberta	
Alberta		Prince Edward Island	
British Columbia		British Columbia	
Ontario	$1820.00	Ontario	1: 2,403

Note

1. There is a striking correlation between these two tables.

2. Prince Edward Island and Saskatchewan fall outside the pattern. In the case of Prince Edward Island, possibly the numbers are too small to be valid. We can offer no explanation regarding Saskatchewan.

by Provinces - 1930

Income per person

in ascending

order of magnitude

Newfoundland	$[illegible]	Newfoundland	[illegible]
Prince Edward Island			
New Brunswick			
Nova Scotia			
[illegible]			
[illegible]			
Manitoba			
Alberta			
British Columbia			
Ontario	$1,[illegible]	Ontario	[illegible]

Note

1. There is a striking correlation between these two tables.

[illegible]

outside the pattern. In the case of Prince Edward Island, possibly the numbers are too small to be valid. [illegible] offer no explanation regarding Saskatchewan.

III

National Accounts - D.B.S.
Income & Expenditure - 1960
Personal Income per Person

Newfoundland	856
Prince Edward Island	971
New Brunswick	1035
Nova Scotia	1177
Quebec	1309
Saskatchewan	1448
Manitoba	1526
Alberta	1573
British Columbia	1806
Ontario	1820
Yukon & N.W.T.	1333
CANADA	1540

IV

Approximate percentage of women dentists in the following countries -

Norway	30 per cent
Sweden	30 " "
Finland	75 " "
Soviet Union	70 " "
Great Britain	7 " "
CANADA	1.5 " "

Prince Edward Island

New Brunswick

Nova Scotia

Manitoba

Alberta

British Columbia

Ontario

Quebec, P.E.I.

CANADA

IV

approximate percentage of women deaths in the Canadian countries -

Norway	30
Sweden	30
Finland	25
Soviet Union	25
Great Britain	1
CANADA	1.1

SECTION J

PROVINCIAL LABORATORY SERVICES

1. Public health and clinical laboratory services are provided to residents in the Province of New Brunswick by the Provincial Laboratory Service, a Division of the Department of Health and by hospital laboratories. The services provided through the Laboratory Division constitute the great majority of these. In addition, many hospital laboratories are to some extent, supervised by the Provincial Laboratory Service and only a few of the smaller hospitals remain entirely independent. The Provincial Laboratory System provides a comprehensive service which offers all ordinary clinical and public health examinations excluding only those unusual and rarely performed procedures which are requested with insufficient frequency to make the performance of them a feasible operation. All tests done by both the Provincial Laboratories and the hospital laboratories are provided without charge to in-patients. Out-patient services are at present organized, as follows:

(a) Syphilis serology tests and the serological investigation of pre-natal cases are provided free to residents of the province and are supported by special federal and provincial grants.

(b) Tissue and cytological examinations, all bacteriological and parasitological examinations and certain specified hematological and biochemical procedures are provided to qualified

[illegible] SERVICE

Public health and clinical laboratory services are provided to residents in the Province of New Brunswick by the Provincial Laboratory Service, a Division of the Department of Health and by hospital laboratories.

Into the great majority of these. In addition, most hospital laboratories are to some extent, supervised by the Provincial Laboratory Service and only a few of the smaller hospitals remain entirely independent. The Provincial Laboratory System provides a complete [illegible] health examinations excluding only those [illegible] rarely performed procedures which are [illegible] sufficient frequency to make the performance [illegible] feasible operation. All tests done by both the Provincial Laboratories and the hospital laboratories are [illegible] at present organized, as follows:

(a) Syphilis serology tests and the serological investigation of pre-natal cases are provided free to residents of the province and are supported by special federal and provincial [illegible]

(b) Tissue and cytological examinations, all bacteriological and parasitological examinations, chemical procedures are provided to qualified

residents of New Brunswick as insured out-patient services of the hospitalization plan. It should be noted that this last group is provided free to residents of New Brunswick only when the work is done in Provincial Laboratories, not when it is done in hospital laboratories. This policy was adopted at the insistence of Federal Health authorities and should be reconsidered. At present there are 11 Pathologists in the provincial laboratory services plus one in the Federal D.V.A. Hospital. Three of the provincial pathologists have not yet written specialist examinations. Future plans and estimates indicate that we require an additional 4 Pathologists to provide the service adequately. At the time of writing we have 6 senior laboratory officers, that is, laboratory workers who hold a university degree. To provide adequate coverage and expansion of service we would require 11 additional laboratory officers with this type of training. There are 75 technicians of varying degrees of experience and training employed in the Regional Laboratory system. In addition, it is estimated that approximately 20 technicians are employed by hospitals throughout the province.

2 It is our opinion that the present system of Regional Laboratories is particularly well adapted to

[illegible] consideration as included in patient services of the hospitalization plan. It should be noted that this group is provided free to residents of New Brunswick only when the work is done in Provincial laboratories, and when it is done in hospital laboratories. This policy was adopted at the insistence of Federal Health authorities and should be reconsidered. At present there are 11 Pathologists in the provincial laboratory services plus one in the Federal D.V.A. Hospital. Three of the provincial pathologists have not yet written specialist examinations. Future plans and estimates indicate that we require no additional Pathologists to provide our service adequately. At the time of writing we have 9 senior laboratory officers, that is, [illegible] degree. To provide a regular coverage and expansion of service we would require 11 [illegible] of varying degrees of experience and training employed in the Regional laboratory system. In addition, it is estimated that approximately 20 technicians are employed by hospitals throughout the province.

It is our opinion that the present system of Regional laboratories is particularly well adapted to

the needs of this province and that it should be continued and expanded in the future. There are now five regions served by these laboratories and a sixth and final region should be developed in the near future. Also, the provision of consultant services by pathologists and laboratory workers to hospital laboratories which are more or less remote from the Regional Laboratories should be expanded to include every hospital laboratory in the province. Technical control of the procedure performed in every hospital laboratory should be exercised by the Provincial Laboratory Service. The physical facilities provided by the Provincial Laboratory Service are excellent. The physical facilities in many of the hospitals are good but, in others, leave much to be desired. It should be our aim to provide each hospital with facilities which are entirely adequate to perform those tests which, in the opinion of the consultant pathologist, should be carried out in a hospital of that particular size and level of activity.

3. Good laboratory services can only be produced by qualified and conscientious people working in adequate physical facilities. No serious difficulty has been encountered in the past in the provision of funds for expansion of facilities or purchase of equipment and none is anticipated. There has always been great difficulty, however, in obtaining sufficient qualified people to staff the Laboratories. This difficulty has been greatly aggravated by the increased work load placed on the Laboratory Service because of the advent of government sponsored hospital insurance. Anticipated extension

served by these laboratories and a sixth and final [illegible]

the provision of consultant services by pathologists and laboratory workers to hospital laboratories which are more or less remote from the Regional Laboratories should be expanded to include every hospital laboratory in the province. Technical control of the procedures performed in every hospital laboratory should be exercised by the Provincial Laboratory Service. The physical facilities provided by the Provincial Laboratory Service are excellent. The physical facilities in many of the hospitals are good but, in others, leave much to be desired. It should be our aim to provide each hospital with facilities which are entirely adequate to perform these tests which, in the opinion of the consultant pathologist, should be carried out in a hospital of that particular size and level of activity.

3. Good laboratory services can only be provided by qualified and conscientious people working in adequate physical facilities. No serious difficulty has been encountered in the past in the provision of staff for expansion of facilities or programme of equipment is not one is anticipated. There has always been great difficulty, however, [illegible]

been greatly aggravated by the increased work load placed on the Laboratory Service because of the advent of [illegible]

of out-patient laboratory services promise to add an even greater load. Over the past ten years, many laboratory workers have been trained in this province, an average of about 18 per year. Of these, many have remained here, others have been attracted to other parts of Canada by higher salaries and better working conditions. There is only one realistic way to solve this problem, and that is by bringing the terms of employment and levels of remuneration up to a par with those in other parts of Canada so that we will be able to compete on an equal fotting with them. The training programme for technicians must be expanded so that sufficient numbers of trained technicians will always be available. One of the most serious needs of the province is for the senior laboratory worker. The Laboratory Servide has been able to attract and retain very few university science graduates. This, again, is because we are not in a position to compete favourably, particularly with industry, for the services of these people. The same observations may be made about the professional laboratory staff. At least 5 more pathologists are required to bring the level of services in this province up to that of other provinces. If we are to retain those already established here and to attract the others required to expand our services, then we must be able to offer terms and conditions of employment which allow us to compete on an equal footing with other provinces.

4. Our general recommendation is that the present system of regional laboratory service in New Brunswick be retained and expanded to include all regions of the

of out-patient laboratory services promises to add an over-
[illegible]
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the others required to expand our services, then we must
be able to offer terms and conditions of employment which
allow us to compete on an equal footing with other
[illegible]

4 Our general recommendation is that the present
system of regional laboratory service in New Brunswick
be retained and expanded to include all regions of the

provinces.

Professional and technical consultation service must be extended to every hospital laboratory in the province, with the object of raising the standards of laboratory work in each hospital to that level which, in the opinion of the consulting pathologists, is commensurate with the size of the size of the hospital and the type of medical practice carried on in it. Physical laboratory facilities in these hospitals must also be brought up to the level necessary tolprovide this standard of service. Conditions of employment within the service must be such as will enable us to attract, train and hold highly qualified personnel at all levels or responsibility: professional, supervisory and technical.

5. The provincial laboratory service is provided to all the province in five regions. There is one chief laboratory, four regional laboratories and two branch laboratories. These laboratories provide all public health laboratory service for the province as well as pathological consultant and clinical laboratory service for all hospitals of the province with the exception of the Department of Veterans' Affairs Hospital at Lancaster owned and operated by the Government of Canada. At this hospital there is a Pathologist and a completely equipped laboratory. To more adequately cover the province for this service in the future, it is evident that an extension of this system is both desirable and necessary. The extension will require one more regional laboratory before 1965. To construct and equip this additional facility will require an expenditure of $190,000.00 and

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will serve an area in the northeastern section of the province. An additional expansion now being implemented is a revision of individual hospital laboratories. These laboratories will do routine tests and procedures both in-patient and out-patient for the area served by the hospital, while the detailed and complicated procedures will be processed at the regional laboratories. Twelve of these hospital laboratories will be utilized more extensively and will be considered as branches of our provincial laboratory service. The estimated cost of this extension is $50,000.00 and such expansion should be finalized before the end of the present fiscal year, March 31, 1962.

6. It is here noted that there has been an annual increase in the volume of this service over the years. The establishment of a hospital service plan was considered likely to result in a marked increase in this service, as stated previously in this section, however, an analysis of our records have not substantiated this assumption. The following statistics are provided to prove that the anticipated increase did not occur.

Year	Units % increase	Tests % increase
1952	base	base
1953	12.8	14.8
1954	38.6	34.0
1955	21.1	45.2
1956	17.5	17.1
1957	23.3	13.9
1958	10.3	5.7

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this extension is $90,000.00 are such expenses which be financed before the end of the present fiscal year, March 31, 1962.

9. It is here noted that there has been an [illegible] increase in the volume of both service [illegible] the establishment of a hospital service [illegible] likely to result in a reduced increase in this [illegible] stated previously in this section, however, an analysis of our records have not substantiated this conclusion. The following statistics are provided to prove that the anticipated increase did not occur.

Year	Units % Increase	Tests % Increase
1953	19.8	14.8
1957	23.4	[illegible]
1958	10.7	[illegible]

1959	13.4	15.5
1960	6.1	21.7
1961 Estimated	11.5	11.4

The operation of the Hospital Service Plan became effective on July 1, 1959.

The annual operating cost of the projected facilities has not been estimated at this time because of the time factor involved in the preparation of this submission. Such estimates will be made available at a later date.

SECTION K

HEALTH PERSONNEL - TRAINING AND STAFF

1. Previous to this date, the undergraduate training of health personnel has been under the Department of Education, while the postgraduate training in this field has been substantially assisted with funds from the Department of Health. Expenditures for postgraduate training under this department are claimed 100% from National Health Grants. The following statistics indicate the volume of training assisted by the Department of Health over the past 12 years set forth in Table I. The expenditures from public funds on training assistance to individuals for the past 10 years is set forth in Table II.

1961 Estimated	11.5	11.4

The operation of the Hospital Service Plan became effective on July 1, 1959.

The annual operating cost of the protected facilities has not been estimated at this time because of the time factor involved in the preparation of this submission. Such estimates will be made available at a later date.

HEALTH PERSONNEL - TRAINING - IN STATE

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[illegible] expenditures from public funds on training assistance to individuals for the past 10 years is set forth in Table II.

TABLE I

TRAINING OF PERSONNEL

PROVINCE OF NEW BRUNSWICK

	Personnel Trained	Personnel in Training	Total
Psychiatrists	19	3	22
Radiologists	12	1	13
Public Health Nurses	55	7	62
Pathologists	5	-	5
Psychiatric Social Workers	32	3	35
Hospital Administration and Management	14	3	17
Teaching and Supervision in Schools of Nursing	84	18	102
X-Ray Technicians	65	17	82
Laboratory Technicians	169	16	185
Training Paediatrics	14	6	20
Physiotherapists	15	8	23
Radiological Physics	1	-	1
Dental Hygienist	1	2	3
Psychologists	28	5	33
Obstetrics	23	1	24
Dietetics	10	1	11
Occupational Therapy	5	2	7
Medical Records Librarian	15	3	18
Psychiatric Nursing	18	3	21
Sanitary Engineers	3	-	3

	Trained	Personnel in Training
[illegible]	19	
[illegible]		
[illegible]	55	
Pathologists	5	
Psychiatric Social Workers	32	
[illegible]		
Registration and Management	14	
Teaching and Supervision in Schools of Nursing		
X-Ray Technicians		
Technicians		
Training Dietitians		
[illegible]		
Radiological [illegible]		
[illegible]		
[illegible]		
Obstetrics	23	
[illegible]	10	
Occupational Therapy		
Medical Records [illegible]	15	
[illegible]	13	
Sanitary Engineers		

Bacteriology	5	-	5
Chemists	3	-	3
Diploma Public Health	4	-	4
Guidance Counsellor	2	-	2
Electroencephalography Technician	5	-	5
Clinical Photography	2	-	2
Speech Therapy	1	-	1
Medical Social Worker	1	-	1
Health Education	1	-	1
Public Health Dentistry	1	-	1
Child Welfare Worker	1	-	1
Master of Public Health	1	-	1
Master of Public Administration	1	-	1
Rehabilitation Social Worker	1	-	1
Nutritionist	1	-	1
Neurology	1	-	1
Nursing Unit Administration	-	2	2
	619	101	720

[illegible]nology	5
[illegible]ats	3
Diploma Public Health	4
Guidance Counsellor	2
Electroencephalography Technician	
[illegible]	
[illegible]	
Medical Social [illegible]	
[illegible]	
Dentistry	
Child Welfare [illegible]	
Master of Public [illegible]	
Master of Public Administration	
Social Worker	
[illegible]	
Neurology	
Administration	

TABLE II

TRAINING ASSISTANCE FOR HEALTH PERSONNEL

PROVINCE OF NEW BRUNSWICK 1952 - 1961

TEN YEARS

Year	Expenditure
1952	$102,505.00
1953	121,600.00
1954	135,100.00
1955	141,500.00
1956	127,000.00
1957	158,500.00
1958	194,200.00
1959	283,700.00
1960	266,800.00
1961 (Estimated)	244,100.00
TOTAL	$1,775,005.00

This assistance was paid directly to the trainee and to the training centre for tuition on behalf of the trainee. The assistance provided tuition, travel, book allowance and monthly stipend, to cover living expenses while training.

2. The physical facilities for the training of health personnel are not extensive in this province and we depend on the good neighbor policy to make available to us the training facilities in many of the specialized fields of training. The population of this province is not sufficiently large to warrant the establishment of

TABLE II

TRAINING ASSISTANCE

PROVINCE OF NEW BRUNSWICK

1954	185,100.00
1955	141,500.00
1956	127,000.00
1957	156,800.00
1958	104,200.00
1959	283,700.00
1960	266,800.00
1961 (Estimated)	244,100.00
TOTAL	$1,375,000.00

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these special training facilities in many fields.

The following health training facilities are available in New Brunswick:

(a) Laboratory Technicians are trained at a central school operated and financed by the Department of Health with assistance from National Health Grants. This school is capable of graduating 24 technicians each year.

(b) Radiological Technicians are trained at four hospital centers in the province. These training centers are capable of graduating 15 technicians annually.

(c) Training facilities for the undergraduate training of nurses consist of 13 hospital training schools for nurses, which are capable of graduating approximately 220 nurses yearly. Since the course is of three years duration, then, at any given time, there could be 660 student nurses in training.

(d) The University School of Nursing established recently is staffed and equipped to graduate 25 nurses annually. This facility provides a four year university course and qualifies the student for a Bachelor of Nursing degree, and also entitled them to sit for the registration examination of the New Brunswick Association of Registered Nurses. This school also organizes and operates numerous short courses, institutes and refresher courses in the post-graduate field of nursing.

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(d) The University School of Nursing recently is staffed and equipped to graduate 25 nurses annually. This facility provides a four year university course and qualifies the student for a Bachelor of Nursing degree, and also enables them to sit for the regist[illegible] examination of the New Brunswick Association of Registered Nurses. This school also [illegible] and operates numerous short courses, institutes and refresher courses in the undergraduate field of nursing.

(e) Facilities for the training of Nurse Assistants are provided at five hospital centers and two vocational training centers.

(f) Mental Hospitals are approved for two years of resident training in psychiatry. Two general hospitals are approved for resident training in Radiology, while three hospitals are approved for interne training.

3. The majority of the foregoing sections contain information regarding deficiency of personnel for the service related to that particular section. Comments on nursing personnel in hospital services and physicians in private practice are provided in the following paragraphs.

(a) Nurses on the active Register in New Brunswick in 1960 totalled 2163, while in 1961, the total has increased to 2304. In addition it is known at the present time that there are approximately 50 graduate nurses working in the province who are not registered. It is stated frequently by various individuals interested in health problems in our province that there is a marked shortage of nursing personnel in the general hospitals of the province. A survey estimate on all the hospitals, except two, which remain to be completed, will set forth this situation as it exists as of this date. This analysis was computed on the basis of all types of personnel engaged in providing nursing service directly to the patient.

(e) Facilities for the training of Nurse Assistants are provided at five hospital centres.

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Student nurses were included on the basis of two students providing the same volume of nursing service as one graduate nurse. Such surveys have indicated that there is an excess of at least 43 personnel in the nursing service of our active treatment general hospitals. From the above, it would appear that we are adequately staffed for this type of health personnel in general hospitals. This view is further supported by statistics from the Canada Year Book, 1960, which indicates that in 1958 the nursing staff to patient ratio was higher in the general hospitals of New Brunswick than any other province in Canada except the province of Ontario, and indeed, at that time, we were 7% above the national average.

4. There are 486 registered medical doctors in this province at this time. In addition, there is approximately 7 doctors at the D.V.A. Hospital, Lancaster, who provide service to veterans resident in the province, but do not appear on the provincial medical register. This would provide an overall ratio of doctors to population of 1:1238. The ratio in 1951 was 1:1530. The national average at the present time is 1:888. The total number of medical doctors are divided in categories as follows:

(a) There are 99 doctors on full time salary.

(b) There are 389 doctors in private practice of medicine of which, 154 are qualified as specialists in the various fields of

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(a) There are 99 doctors on full time salary.

(b) There are 249 doctors in private practice of medicine of which, 154 are qualified as specialists in the various fields of

medicine.

Please refer to the following tables and sketch map for distribution of medical manpower in New Brunswick.

Medical Personnel in Private Practice in New Brunswick by Hospital Regions

Total: 389

	Regular Physicians	Specialists	General Practitioners
Region 1	54	24	30
Region 2	20	2	18
Region 3	94	62	32
Region 4	95	41	54
Region 5	35	6	29
Region 6	24	3	21
Region 7	27	10	17
Region 8	40	6	34
TOTALS	389	154	235

Please refer to the following tables and

for distribution of medical manpower in New Brunswick.

Medical Personnel in Private Practice in New
Brunswick by H[illegible]

	Physicians	Specialists	Practitio[illegible]
[illegible]	34	24	
[illegible]	20		
[illegible]	94	62	
[illegible]	95	41	
[illegible]		6	
[illegible]		3	
[illegible]		10	
[illegible]			
TOTALS			

Population Served by Medical Personnel in Private Practice in New Brunswick, by Hospital Regions, showing:

	(a) Physician - Population Ratio	(b) Specialist - Population Ratio	(c) Gen. Practitioner - Population Ratio
Region 1	1:1290	1:2902	1:2322
Region 2	1:1228	1:12280	1:1365
Region 3	1:1317	1:1998	1:3871
Region 4	1:1368	1:3176	1:2407
Region 5	1:1726	1:10066	1:2083
Region 6	1:1194	1:9533	1:1336
Region 7	1:1629	1:4401	1:2589
Region 8	1:3071	1:20472	1:3613

* See Map and Table on next page showing all medical personnel, including salaried physicians, by Hospital Regions.

[illegible]

[illegible]

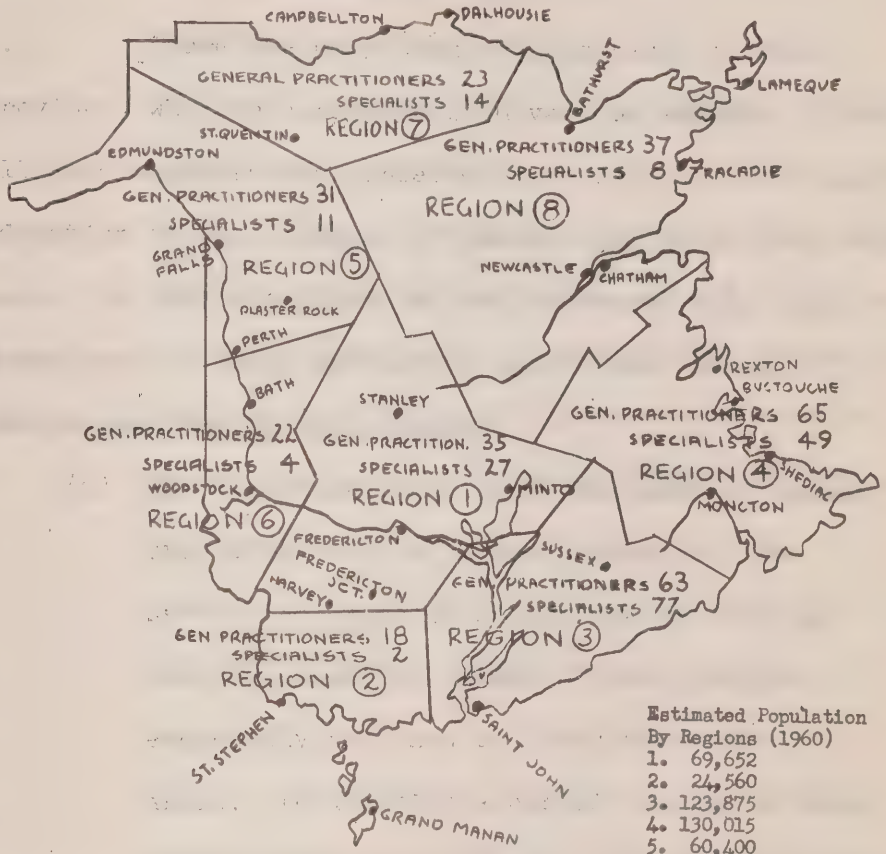
[illegible]

	(a) Physician - Population	(b) Specialist - Population Ratio	(c) Gen. Practitioner - Population
[illegible]	1:1290	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	1:1305
[illegible]	1:1317	[illegible]	[illegible]
[illegible]	1:1305	1:3176	1:2407
[illegible]	1:1726	[illegible]	1:2083
[illegible]	1:1194	[illegible]	[illegible]
[illegible]	1:1629	1:4401	[illegible]
[illegible]	1:3071	[illegible]	[illegible]

* See Map and Table on back page showing all medical personnel, including salaried physicians, by Hospital Regions.

DISTRIBUTION of MEDICAL PRACTITIONERS in NEW BRUNSWICK

BY HOSPITAL REGIONS



Estimated Population
By Regions (1960)

1. 69,652
2. 24,560
3. 123,875
4. 130,015
5. 60,400
6. 28,658
7. 44,008
8. 122,832

604,000

REG. PHYSICIANS, 486 - GEN. PRACTITIONERS, 294 - SPECIALISTS, 192

DISTRIBUTION OF SPECIALISTS

SPECIALTY	HOSPITAL REGIONS								
	1	2	3	4	5	6	7	8	TOTALS
Medicine	4	-	16	8	2	-	-	-	30
Surgery	8	1	23	20	5	1	8	4	70
Obstetrics) Gynaecology)	3	-	6	3	-	-	1	-	13
Neurology	-	-	2	-	-	-	-	-	2
Ophthalmology) Otolaryngology)	3	1	6	5	1	1	2	1	20
Anaesthesiology	2	-	5	4	1	-	-	1	13
Pediatrics	2	-	3	2	1	-	-	-	8
Psychiatry	1	-	4	2	-	-	1	-	8
Urology	1	-	3	1	-	-	-	-	5
Pathology	2	-	3	2	-	-	1	-	8
Radiology									
Diagnostic	-	-	1	-	-	2	1	2	6
Therapeutic	-	-	2	-	-	-	-	-	2
Both	1	-	3	2	1	-	-	-	7
TOTALS	27	2	77	49	11	4	14	8	192

SECTION L

VOLUNTARY AGENCIES

1. There are many such organizations in this province, who are concerned with various aspects of health. All such agencies are concerned with publicity and health education in that segment of health care which they represent. In this submission we are concerned only with the organizations which provide an appreciable amount of health services to individuals.

(a) The Victorian Order of Nurses have 40 nurses providing service in New Brunswick. The service consists of public health nursing service in certain areas of the province, especially confined to towns and urban areas. In addition a certain volume of home nursing care is provided. Assistance is provided to this agency from provincial funds for the public health service they provide to the extent of $31,250.00 annually. The home nursing service is provided for a small fee to those who can pay and to those who cannot pay the service is provided free of charge.

(b) The New Brunswick Tuberculosis Association has had a long and excellent record in providing service in this field. At the present time this agency provides the major cost of operating a mobile X-ray facility throughout the province, as well as substantial service in the field of rehabilitation of individuals who have been

SECTION B

[illegible]

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(b) The New Brunswick Tuberculosis Association has had a long and excellent record in providing service in this field. At the present time this agency provides the major cost of operating a mobile X-ray facility throughout the province, as well as substantial service in the field of rehabilitation of individuals who have been

treated for tuberculosis.

(c) The Saint John Ambulance Society provides a comprehensive instruction service in all aspects of first aid to the injured, as well as providing a province wide ambulance service for emergency transport of the ill and all sick persons who are unable to provide this service on their own responsibility. In the past, financial assistance was provided to this agency from the Department of Health for the purchase of ambulance vehicles to the extent of $4,000.00 annually.

(d) The Red Cross Society provides certain nursing service in out-posts and public health regions of the province. A grant in aid for this service was provided to this agency in 1960 to the extent of $1,300.00. The major service, which is indeed a valuable one, is that of the Red Cross Transfusion Service. To assist the service, a grant of $5,000.00 annually towards the operation of the provincial Red Cross Depot and $30,000.00 to assist in the technical costs of processing the blood relative to the supply utilized in this province. This service is now a facility under the Hospital Service Plan.

(e) The Foundation for Poliomyelitis provides personal benefits and care to individuals disabled by poliomyelitis. The major service now provided is an adult immunization program against this disease. This agency organizes

treated for tuberculosis.

(c) [illegible]

comprehensive instruction service in all aspects of first aid to the injured, as well as providing a province wide ambulance service for emergency transport of the ill and all sick persons who are unable to provide this service on their own responsibility. In the past, financial assistance was provided to this agency from the Department of Health for the purchase of ambulance vehicles to the extent of $4,000.00 annually.

(d) The Red Cross Society provides medical nursing service in out-posts and public health regions of the province. A grant in aid for this service was provided to this agency in 1954 to the extent of $1,300.00. The major service, which is indeed a valuable one, is that of the Red Cross Transfusion Service. To assist the service, a grant of $3,000.00 annually towards the operation of the provincial Red Cross Depot and $50,000.00 to assist in the erection of a of processing the blood relative to the supply utilized in this province. This service is now a facility under the Hospital Service Plan.

(e) The Foundation for Poliomyelitis provides personal benefits and care to individuals disabled by poliomyelitis. The major service now provided is an adult immunization program against this disease. This agency organized a

and operates the immunization clinic, while the Department of Health provides the vaccine necessary for this service with assistance from National Health Grants.

(f) The Canadian Arthritis and Rheumatism Society (New Brunswick Branch) renders service to individuals by the operation of two stationary clinics and two mobile physiotherapy clinics located in the south and central portion of the province. To initiate these two mobile services, assistance was provided to the extent of $17,500.00 by the Department of Health and claimed from National Health Grants.

(g) The Canadian Cancer Society provides funds for research and in addition personal benefits and care are provided to some cancer patients outside hospital who are not able financially to provide such items on their own behalf.

(h) The Canadian National Institute of the Blind provides service to individuals through two clinics operated at intervals in the province.

2. Many other agencies provide excellent service in the field of health education, co-ordination and public relations.

Department of Health provides the vaccine necessary for this service with assistance from National Health Grants.

(f) [illegible]

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(h) The Canadian National Institute of the Blind provides service to individuals through two clinics operated at intervals in the province.

[illegible]

in the field of health education, co-ordination and publication.

SECTION M

PRESCRIPTION DRUGS

1. The provision of prescription drugs is assuming increasing proportions both as to increased utilization as is shown by the increasing number of prescriptions per thousand of population and an increasing cost per service or prescription. It is felt that if generic, chemical or non-proprietary nomenclature were used this could result in an appreciable saving on this service.

2. At the present time drug therapy in all the hospitals of the province is being provided to in-patients from public funds at a total annual cost of $1,263,000.00 or a per capita cost of 32.04. Approximately 50% of this cost is claimed from the Government of Canada and the remainder is provided by the Government of New Brunswick.

3. If prescription drugs were extended to the population outside hospitals, excluding certain items such as vitamin preparations, that may properly be considered a food supplement in most cases, then the estimated cost in this field for 1962 would be $1,922,000.00 or a per capita cost of $3.10. Then there would be a total cost of prescription drugs of $3,185,000.00 for all the population or a total per capita cost of $5.14.

4. The provision of prescription drugs to the population from public funds probably should be considered next to medical care on the list of priorities for health services. It is realized, however, that this item of

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4. The provision of prescription drugs to the population from public funds probably should be considered next to medical care on the list of priorities for health services. It is realized, however, that this item of

health services, when provided from public funds, may easily be subject to abuse in the field of over-utilization both by the providers of the service and the receivers of the service.

5. The foregoing estimates may be subject to revision at a later date after further research and statistics are analyzed.

SECTION N

ESTIMATED COSTS OF HEALTH SERVICES PRESENTLY NOT PROVIDED BY PUBLIC FUNDS

1. These estimates are computed on the basis of providing that segment of health care presently being provided by the medical doctors of this province by the method of private practice. We have excluded medical care provided under Acts of Federal and Provincial jurisdiction and their Regulations. It is estimated that the population of the province will be 620,000 in the year of 1962. It seems evident that slightly over 3% of this population is covered for this service by the Acts previously mentioned. The net population to be covered in 1962 would be 600,000.

Estimates are made in three parts having regard to priority:

(a) Number one priority would be medical service all maternity care.

From statistics available, it is estimated there will be 18,000 obstetrical cases in New Brunswick in 1962. The total cost of this

health services, when provided from public funds, may easily be subject to abuse in the field of over-utilization both by the providers of the service and the receivers of the service.

5. The foregoing estimates may be subject to revision at a later date after further research and statistics are analyzed.

SECTION N

ESTIMATED COSTS OF HEALTH SERVICES PRIMARILY NOT PROVIDED BY PUBLIC FUNDS

1. These estimates are computed on the basis of [illegible] provided by the medical doctors of this province by the method of private practice. We have excluded [illegible] care provided under Acts of Federal and Provincial [illegible] diction and their Regulations. It is estimated that the population of the province will be 630,000 in the year of 1962. It seems evident that slightly over 3% of this population is covered for this service by the Acts previously mentioned. The net population to be covered in 1962 would be 600,000.

Estimates are made in three parts having regard to priority:

(a) Number one priority would be medical service all maternity care.

From statistics available, it is estimated there will be 10,000 obstetrical cases in New Brunswick in 1962. The total cost of this

segment of service is estimated at $1,638,000.00 in 1962 or a cost of $2.64 per capita of total population.

(b) Number two priority would be medical service for all children up to the seventeenth birthday. The estimate for this group in our population in 1962 is 438,000 children. It is further estimated that the total cost of providing this service for this group of the population would be $4,860,800.00 in 1962 or a cost of $7.84 per capita of total population.

(c) Number three priority would be the provision of this segment of health services to all the population excluding those covered by present Acts of Federal and Provincial jurisdiction. It is estimated that these Acts cover approximately 3% of the population or 18,000 people. Then total population in 1962 of 620,000 - 18,000 equals 602,000 eligible persons under such a plan. Estimated total cost of such a service in 1962 would be $12,341,000.00 or a cost of $19.90 per capita of the total population.

The cost of prescription drugs provided to individuals not in hospital is included in the above estimates, except vitamin preparations which are excluded on the basis that these preparations are, in the main, used

$1,238,000.00 in 1952 or a cost of $2.34 per capita of total population.

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(c) Number three priority would be the provision of this segment of health services to all the population excluding those covered by present acts of Federal and Provincial jurisdiction. It is estimated that these Acts cover approximately 3% of the population or 16,000 people. Then total population in 1952 of 620,000 - 16,000 equals 602,000 eligible persons under such a plan. Estimated total cost of such a service in 1952 would be $12,441,000.00 or a cost of $19.90 per capita of the total.

The cost of prescription drugs provided to individuals not in hospital is included in the above estimates, except vitamin preparations which are excluded on the basis that these preparations are, in the main, used

as a food supplement.

In any future extension of health services that might be provided from provincial public funds, it is hoped that substantial assistance from the Government of Canada would be provided, giving due regard to fiscal need of the area or province concerned.

Respectfully Submitted,

THE DEPARTMENT OF HEALTH
Province of New Brunswick

Georges L. Dumont, M.D.
- Minister -

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THE CHAIRMAN: Thank you very much, Dr. Dumont. I might say that the document which you have presented is a very complete and readable one and contains a volume of information which we might have had to search for elsewhere, and perhaps you will appreciate that because you have given such a complete picture the number of questions that may be asked are very substantially reduced, because the information is already here. There will be, however, some questions that members of the Commission will put in order to perhaps understand better the submission and to perhaps amplify in a few areas the information that has been given. Your submission covers the whole field of health services in New Brunwsick, and naturally we are concerned with all those phases, but very particularly we are concerned with health personnel, because we have been told, for instance, in one or two of the provinces where we have been that if a programme to cover complete health services were to be proposed tomorrow the personnel does not exist to man or put such a programme into effect.

Now, what would be your view on that, Dr. Dumont, in the Province of New Brunswick? You appear to be better situated than the other three Atlantic Provinces in terms of manpower, in terms of personnel, but what are your obvious weaknesses in that respect at the present time?

DR. DUMONT: Well, Mr. Chairman and members, I should think that we would require some 110 doctors. We would also require means of having them established to give full coverage, because it is a matter

THE CHAIRMAN: Thank you very much, Dr. Dumont. I might say that the document which you have presented is a very complete and readable one and contains a volume of information which we might have had to search for elsewhere, and perhaps you will appreciate that because you have given such a complete picture the number of questions that may be asked are very substantially reduced, because the information is already here. There will be, however, some questions that members of the Commission will put in order to perhaps understand better the submission and to perhaps amplify in a few areas the information that has been given. Your submission covers the whole field of health services in New Brunswick, and naturally we are concerned with all those phases, but very particularly we are concerned with health personnel, because we have been told, for instance, in one or two of the provinces where we have been that if a programme to cover complete health services were to be proposed tomorrow the personnel does not exist to man or put such a programme into effect.

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DR. DUMONT: Well, Mr. Chairman and members, I should think that we would require some 110 doctors. We would also require means of having them established to give full coverage, because it is a matter

of experience that the doctors, physicians, especially when they are specialised, when they get particular training in one field, they all flock to the cities and the larger centres, leaving uncovered or poorly covered certain areas. There is always in life, even with physicians and nurses, an incentive,and that is money. So they would resent, some of them, taking office or duties to serve if they are sure of not being able to make a normal living, especially when they are deprived of the facilities and the standards of life, accepted standards of life.

We have areas where there was coverage at one time, but now the doctors have gone out, and there are areas where the density of population is quite high and they have to drive out some thirty-five miles to get medical care; the area is not covered. If this area was covered, where the physician would be assured of a livelihood, where he would have a decent salary, he would establish there, but this would call for a certain degree of work. That is my view on this particular problem.

Why is it that in one city there will be seventy-five or ninety doctors, some of them not fairing too well, but still they want to live the same. It is not particular to the medical profession; they want to live in the city and they want to specialize, they want to have hospital facilities. That is another thing which we must take into consideration. If we organize other hospitals all in large centres and allow our hospitals only to be large and big hospitals at some distance of seventy-five, eighty miles from the centres,

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that is another reason why doctors will not establish in those areas, and the doctors nowadays want to have access to some hospitals.

So I think it would be wise to see to it, while we don't want to see the standards of larger hospitals go down, there should also be provided to serve the community smaller hospitals, cottage hospitals, where one or two doctors would be established and enjoy normal practice, and I think the profession would concur in that viewpoint.

THE CHAIRMAN: Do you wish to add anything, Dr. Kelly?

DR. KELLY: The only thing I wish to add is this, that if a country or a profession waits until they have adequate facilities in all fields before any type of a system is provided for health services for other people, we will never have them. In the days of providing health services I think I can safely say that there was not a province in this Canada of ours that had adequate hospital facilities, but they are coming near the point where they will have them in a few years. I think myself that the lack of trained personnel is not a deterent to the establishment of a system of giving health services to all other people, and when I say all other people, I mean the people in the sparse rural areas and who are not getting sufficient services at the moment, either because the personnel are not available or because they have not the money to purchase them.

THE CHAIRMAN: Thank you, Doctor. In your summary, Dr. Dumont, you mentioned that the

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THE CHAIRMAN: Thank you, Doctor.

In your summary, Dr. Dumont, you mentioned that the

province had participated in a post-graduate training of health personnel. That is one page 3, item k, I am referring to at the moment. I am just using this as the basis for a more general question, a question which will have more application to these 720. You say that 720 have been trained at an annual expenditure of about 250 thousand dollars, which is a programme of some considerable magnitude.

Can you tell the Commission, having trained that 720, how many have remained for service to the Province of New Brunswick?

DR. KELLY: Mr. Chairman, the only survey which we have made is in the category of mental health personnel, and when this survey was made some two years ago, of the 51 we had trained in mental health, 31 were remaining with us, 20 had left us. In the field of mental health we suffer the most casulties. In certain other fields, x-ray technicians, laboratory technicians, our losses are very low, except through marriage, a thing we can't prevent. By and large I don't believe that our losses have been great, but in the fields where they have been great, mental health, for example, and especially in the professional medical personnel we have trained, we have lost these. I cannot say exactly why. I have an idea that some of them like the large cities, such as Montreal and Toronto; others like our neighbours to the south, and others like higher remuneration. I think almost in every case when the move was made by these people they did receive higher remuneration.

THE CHAIRMAN: To assist these

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THE CHAIRMAN: To assist those

people do you put on any conditions of returning to the province for a certain time?

MR. KELLY: Yes. We have bursary commitments. For example, if we train an individual for two years we take a bursary commitment for a term of service, two years, and in a few cases we have taken as much as four years. But usually we don't do this; usually it is equal to the training time, and usually we receive a refund of the training commitment when it is not satisfactory, but apparently, we are told, it is not legal to collect it, and if we do collect it, we don't in effect lose it from public funds. But we have that expense, and the person goes to the Province of Ontario and perhaps even to the Province of Saskatchewan, which is a beautiful province. But we have lost the money, and we could have used it for somebody else who would have stayed with us. This causes us some concern.

COMMISSIONER McCUTCHEON: Do these people require to practice in any particular part of the province?

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COMMISSIONER McCUTCHEON: In fact people require to practice in any particular part of the province?

DR. KELLY: No, generally we ask a hospital or health facility to sponsor them, which means this hospital or health facility is saying they will employ them when their training is completed. However, if there is any difficulty between the hospital and the person, or if the person says I prefer to live in the north of the province, then anywhere in the Province of New Brunswick is satisfactory. A problem we have is, as you are aware, the French speaking population is almost equal to the English speaking population of our province now, and we have to train bi-lingual and English speaking personnel. There is no other province which has such a problem. Quebec is mostly French speaking, and Ontario does not have the problem. When you get a province with this problem, for instance, when we train a physiotherapist for the south of the province, we should also train one for the north of the province.

THE CHAIRMAN: How do you go about recruitment then?

DR. KELLY: We use every means possible. We have at times in the past sent people up to the high schools to speak to the students. We have tried to make it known to the people of all facilities that these grants are available if they want people trained. If no one else will sponsor them, we will sponsor them in the Department of Health, because we want them trained.

THE CHAIRMAN: I had intended to ask you about the bi-lingual implication, and I am very glad you brought it up. In paragraph m on page 4, you give gross and per capita costs of drugs. Are you in a

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THE CHAIRMAN: I had intended to ask you about the bi-lingual implication, and I am very glad you brought it up. In paragraph m on page 4, you give gross and per capita costs of drugs. Are you in a

position at all to make an estimate of what is spent for drugs, that is not prescription drugs, but drugs that are sold over the counter?

DR. KELLY: No, Mr. Chairman, I am not in that position. This is as difficult to make an estimate on as it is difficult to make an estimate on the cost of cosmetics, and I understand they are both staggering sums. I would like to comment here, however, that I believe that my estimate of prescription drugs outside of hospital may be slightly low, and I would like to say here and now, with the permission of the Minister, that we plan to give you a small supplementary submission, probably in April or when the time comes.

THE CHAIRMAN: That would be excellent, Dr. Kelly.

DR. KELLY: It would no doubt revise some of our financial estimates. I may not have said it in here, but most of our financial estimates are plus or minus 10 per cent, and there are additional estimates, and these are annual estimated costs of the extended hospital facilities.

THE CHAIRMAN: That would be very good, and I think that in the time you had we certainly can only compliment you for what you have done, but any further information that you will be able to compile, any computations that you will be able to make, will be most gladly received, because the more accurate the information is, then the better for everyone.

On page 5 you say to provide complete health services would cost an additional $25.35 per

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On page 5 you say to provide complete health services would cost an additional $25.35 per

capita. Would you care to say what is included in the word complete?

DR. KELLY: Included in this is that portion of health services that is not now supplied from public funds, and I left out three words there. It should have said exluding home care. This is not included in it. I would like to apologize for the errors and omissions in this, but we didn't have time to proof read it very much, so there will be some errors in English and spelling, but what is meant by this factor is health services not now provided from public funds excluding home care.

THE CHAIRMAN: By home care, do you mean anything more than nursing care in the home?

DR. KELLY: Yes, that is what I mean.

THE CHAIRMAN: Now, this figure of $25.35. Are you able to tell us roughly how you arrived at that, we appreciate it is an estimate.

DR. KELLY: Yes, it is, I realize this too. However, I might say to you here and now that I had worked four years ago, as a matter of fact it is five years ago now, on this same problem of projecting costs, and I had projected my costs at that time to the year of 1960. This was not only hospital services, but also medical care and dental care and things such as this. At that time I used the Dominion Bureau of Statistics figures and so forth.

THE CHAIRMAN: That was the 1951?

DR. KELLY: Yes, and the Dominion Bureau of Statistics, and I also took a look at the

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DR. KELLY: Yes, and the Dominion Bureau of Statistics, and I also took a look at the

medical welfare plans, medical plans for welfare groups that are operating across Canada at the present time, of which our own province has none, and Alberta, as a matter of fact, most provinces have one except New Brunswick and Prince Edward Island, and I attempted to arrive at this cost. I don't know if I should say this. I didn't put it in here, that the cost of professional medical services was estimated. In making this estimate I used 85 per cent of the schedule of fees -- I know the medical profession is going to tell me I didn't have any basis for this, but I understand that in various other provinces the medical profession are accepting from voluntary sponsored plans this scheduled fee of 85 per cent. This is what I used here, which may make this look slightly small.

THE CHAIRMAN: What part of the $25.35 is allotted to medical services?

DR. KELLY: $19.90.

THE CHAIRMAN: So it is to that that the 85 per cent would have relevance?

DR. KELLY: Yes, and the remainder is dental services.

THE CHAIRMAN: Thank you very much, Dr. Kelly.

COMMISSIONER BALTZAN: Mr. Chairman, I must say that this brief is so complete that it hardly leaves any room for any questions, so I wondered if possibly an explanation for perhaps one or two things. I read on page 3 at k :

"All nursing personnel in general hospitals at

that are operating across Canada at the present time, of which our own province has none, and Alberta, as a matter of fact, most provinces have one except New Brunswick and Prince Edward Island, and I attempted to arrive at this cost. I don't know if I should say this. I didn't put it in here, that the cost of professional medical services was estimated. In making this estimate I used 85 per cent of the schedule of fees -- I know the medical profession is going to tell me I didn't have any basis for this, but I understand that in various other provinces the medical profession are accepting from voluntary sponsored plans this scheduled fee of 85 per cent. This is what I used here, which may make this look slightly small.

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THE CHAIRMAN: Thank you very much, Dr. Kelly.

I must say that this brief is so complete that it hardly leaves any room for any questions, so I wondered if possibly an explanation for perhaps one or two things. read on page 3 at k :

"All nursing personnel in general hospitals at

this time show an excess of 43 over the standard requirement."

Does that mean that you have more applications for nurses training than you can accommodate?

DR. KELLY: No. This, Mr. Commissioner, does not apply to nurses in training. This applies to nurses employed in the hospitals throughout our province. This was looked at hospital by hospital by our consultant in nursing, and this is the figure which we came up with. I might point out that we are using here in these statistics the service rendered by two student nurses is equal to the service rendered by one graduate nurse. This is what we used, therefore, we are counting our total student nurses in the hospital schools of training divided by two, would be the figure which would be used for service, and to this we add the graduate nurses.

I was a little disturbed by this figure, but when I went to the Canada Year Book and found that in 1958 we were exactly in this position, we had a higher ratio of nursing personnel to patients than anywhere else in Canada except Ontario, and I could see no reason why the Province of New Brunswick, a poor province we say and everybody else says, should have a higher ratio of professional personnel to patient any higher than the national average.

COMMISSIONER BALTZAN: And you have a good number of applications for nurses in training?

DR. KELLY: Our major schools, I believe, are turning down a few applications. I would imagine that the New Brunswick Association of Registered

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Nurses could give you more definite information on this, but my impression is, and I know the hospital locally here turns down one or two. Certain of our other major hospital training schools for nursing have turned down, one in particular this year turned down several.

DR. DUMONT: But, on the other hand there are other smaller schools of nursing that would desire more applicants, so it is off-set, the other situation.

COMMISSIONER BALTZAN: My special interest in this question is because I have taught nurses for thirty years, so I wanted to give the proper explanation to you, Miss Girard.

COMMISSIONER GIRARD: Mr. Chairman, I will just be brief with one question, because Dr. Baltzan has asked some of the questions I was proposing to ask. What standard was used when you mentioned an excess of 43 over the standard requirements?

DR. KELLY: I believe it was the consultant in nursing in our hospital division who provided this for me, but I believe the standard she used was the national standard of hours of nursing per patient. I presume that was it. I didn't know enough about nursing to question her on it.

COMMISSIONER GIRARD: I was asking this because I doubt if we have a national standard, and I think this is something we need very, very much.

DR. KELLY: What about if we changed the word standard to adequate? I may have been the one who put in the national instead of adequate, but I

but my impression is, and I know the hospital locally here turns down one or two. Certain of our other major hospital training schools for nursing have turned down, one in particular this year turned down several.

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DR. KELLY: What about if we changed the word standard to adequate? I may have been the one who put in the national instead of adequate, but I

perhaps got this from the fact that I looked at the national average in the Canada Year Book, and then for New Brunswick's average, and when I see New Brunswick's average above the national average, either in dollars or personnel, I am a little disturbed, because I don't think it is necessary.

THE CHAIRMAN: Arising out of that, in the administration of the hospital programme of providing hospital care under the federal-provincial programme in New Brunswick, does the Department restrict the number of nurses and set up an arbitrary ratio?

DR. KELLY: No, not yet our Minister says.

THE CHAIRMAN: Are you aware that that is done in other provinces?

DR. KELLY: I was aware of that, yes.

THE CHAIRMAN: And in Saskatchewan?

DR. KELLY: Yes.

COMMISSIONER STRACHAN: Mr. Chairman, referring to the dental health section which is actually i rather than g I find, on page 7, the bottom sub-paragraph, student assistants. Is any serious consideration being given by the government to subsidize dental students?

DR. KELLY: Subsidization of dental students could cause a problem. I presume you are speaking of a subsidization from high school through dental school? This could cause a great problem and I am certain that we would end up, within two or three years, by subsidizing all medical students and all under-

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graduate students, and actually, financing of undergraduates in our province has always been looked on as a function of the Department of Education, while post graduate financing is looked on as a function of the Department of Health. It would be dangerous, because we would end up financing all students in high school going into any kind of health work.

COMMISSION STRACHAN: Do you have any solution to your dental-population ratio?

DR. KELLY: No, I don't have any solution to this, but I think however, that a publicity campaign might result in more people taking dentistry. I think we should concentrate more on the female. They make excellent dentists, our director of dental health tells me.

COMMISSIONER STRACHAN: That is recognized.

DR. KELLY: Yes, I have no solution to any of these problems of getting students to train, and I am not sure whether this is a result of a dislike for the profession, or whether it is a result of low remuneration, or whether it is in fact that our people may be training, some of them, and they may not be coming back to our province. They may be going to one of our other, more prosperous and more beautiful provinces.

THE CHAIRMAN: I think you should separate those words.

DR. DUMONT: That does not exist.

COMMISSION STRACHAN: Would the same principle not be in effect, as you have suggested,

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DR. DUMONT: That does not exist.

COMMISSIONER STRACHAN: Would the principle not be in effect, as you have suggested,

regarding other personnel, that they return and give equal service?

DR. DUMONT: There are wonderful opportunities in so many fields for our young ones graduating from high school. I think they are not aware of the opportunities they are offered. Take for example in the field of physical medicine, rehabilitation, physiotherapists are so needed. We should have these people trained. They would be a wonderful asset in our hospitals, and medical care, and there are others, technicians, well, we are doing not so badly with some of our laboratory technicians and others, well, dietitians for example. This is a need. We should have them all. We have problems in nutrition in this province. There are areas where, believe it or not, we had last year an explosion of scurvy in some of our rural districts. It is unbelievable, but still it is a fact, and under-privileged families and children not receiving, and if we had these nurses, competent dietitians, it would be a wonderful help, so there it is. There might not be enough either enticement for these particular fields, or maybe our young ones are not made aware of the opportunities. That will be one of the answers I feel. There should be more publicity.

COMMISSION STRACHAN: How extensive is your training of nursing assistants, and do you train male nursing assistants?

DR. KELLY: No, we don't train male nursing assistants, not so far. As far as I know, and I might stand corrected on this, perhaps six schools

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I believe the facilities for such training should be expanded in this province. This may be the answer if we are short of personnel like people say we are, although I am not convinced that we are short entirely of personnel. We may have some deficiencies in certain hospitals; I am sure we have deficiencies in nursing personnel. Certain other hospitals must be over-staffed.

THE CHAIRMAN: I want to go back: I had intended to pursue one question in connection with drugs, and that is a reference on page 5 of the section dealing with child and maternal health services. You refer to drugs, and this statement is made:

> "It would seem that if a medical care plan includes drugs, certain principles should be considered".

Then you go on to say:

> "It would seem necessary to require a token amount of payment towards each prescription. This should be at a flat rate, easy to be collected and except only specified, easily identified population groups."

I was wondering if you would care to amplify on that and tell the Commission just specifically what you had in mind?

DR. KELLY: I think our director of child and maternal health has brought this forth, and I may have to refer to her if I get into difficulties.

THE CHAIRMAN: Indeed.

DR. KELLY: I would presume the token payment is the unpopular or popular -- whichever

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way you look at it -- deterent charge.

THE CHAIRMAN: A utilization charge?

DR. KELLY: Yes. The flat rate, I can say we don't all agree within our own department. I would not agree with a flat rate, myself. I would think it should be a percentage rate of the cost on this, and this has gone on to say that this should be collected except in easily identified population groups, and I notice below, "such as mother's allowance, unmarried mothers, and possibly also those unemployed" -- this should not apply to them, but it should apply to all others.

THE CHAIRMAN: Do you think it should apply to what is becoming known as the medically indigent?

DR, KELLY: It probably should because the medical indigent would be the individual, probably, who would be the result of this so-called over-utilization that everyone speaks of. These are the people who get the most services when they are being paid for by public funds.

THE CHAIRMAN: This comes in the part relating to child care?

DR. KELLY: Yes.

THE CHAIRMAN: In a programme of over-all medical care, including the provision of drugs, would you say this principle should apply only in this area, or throughout the whole field?

DR. KELLY: No, this is not what was intended. This was intended to apply if a plan came in only for the children's group -- priority 2.

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THE CHAIRMAN: [illegible]

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DR. KELLY: No, this is not what was intended. This was intended to apply if a plan came in only for the children's group -- priority 2.

THE CHAIRMAN: But if there was a general plan, then would you think there should be a deterent charge to everyone except certainly easily identified population groups?

DR. KELLY: I would think on this segment of health services, yes, because this could easily be the most abused segment of a health service, not only abused by the receivers of the service, but could be abused by the providers of this service.

THE CHAIRMAN: Thank you, Doctor.

COMMISSIONER McCUTCHEON: In the next paragraph, I take it this would have general application too: You suggest there be a limit on the type of drugs that could be prescribed. How, in your opinion, would that affect medical research? Isn't that going to bar the use of new drugs in many cases?

DR. KELLY: I don't know. I don't think this is intended to bar the use of new drugs. Once they became accepted drugs, then they probably could be prescribed, but before they were accepted -- in other words, when they were in research stage -- no, I don't think so, because this is purely research and should come under research grants rather than under a medical care plan. Once they have become approved and are accepted by the appropriate authorities, then they could easily be included in this and would not be excluded.

COMMISSIONER McCUTCHEON: They only become accepted, surely, after fairly extensive use?

DR. KELLY: In the new drugs that have come into effect by and large since I graduated in

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medicine, most of these drugs were accepted before they ever reached this part of the country.

COMMISSIONER McCUTCHEON: Thank you.

COMMISSIONER FIRESTONE: Mr. Minister, this is a very carefully thought out submission. It is well documented, and your recommendations are specific, including the financial implications. We are also encouraged to hear from Dr. Kelly that we may get a supplementary submission. Would it be appropriate, Mr. Minister, if our research staff on going through this very constructive and helpful brief were to address specific questions to your department for supplementary information?

DR. DUMONT: Certainly. We certainly would be willing as far as we can provide that information to supply it to your Commission.

COMMISSIONER FIRESTONE: Thank you, and that can then be included in the supplementary submission you are offereing to make available.

DR. KELLY: Certainly as far as we are able.

DR. DUMONT: There are limitations, even with our own administration.

COMMISSIONER FIRESTONE: Well, judging from the competence, sir, that administration does not seem to be very limited.

May I turn to section A, page 3, the fourth paragraph. Mr. Minister, perhaps yourself or Dr. Kelly could explain to us what you had in mind when you speak of, "the principle of allotting these grants related

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May I turn to section A, page 3, the fourth paragraph. Mr. Minister, perhaps yourself or Dr. Kelly could explain to us what you had in mind when you speak of, "the principle of allowing these drugs [illegible]

in part to a per capita basis, has resulted in an annual reduction in many of the grants, due of course, to the fact that the richer provinces are having a proportionately greater annual increase in population. This means to a certain extent, that the money is being diverted from the economically poor provinces to the richer ones." Could you please explain how?

DR. KELLY: These grants are allotted on a fixed sum plus a per capita. The fixed sum is a rather small sum for each province, and then the per capita is naturally related to the population. I can give you one example, I think -- I could give you several but this one stands out -- but when these grants were initiated on April 1st, 1948, the tuberculosis control grant was $185,000.00 for the Province of New Brunswick. Three years ago, before it was reduced by ten per cent because of the aspects of tuberculosis control, it had dropped to $159,000.00. The total lump sum the Department of National Health and Welfare had voted for these grants had remained the name, but our tuberculosis control grant had dropped from $185,000.00 down to $159,000.00. What happens, of course, is that if our population gain per capita is lower than the population gain per capita of British Columbia -- and it always is -- and of Ontario, and it always is, and of Quebec, and it always is, then we are gradually getting a decreasing sum of money. Sometimes it is only a thousand dollars a year, or sometimes it is around $5,000.00, and this is exactly what I have said here. This money is not kept at National Health and Welfare. It is put on to the richer provinces

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because they had a bigger gain in population. I contend it should be the other way around. The place where incomes are low and living standards are low, compared to another province, needs more health services rather than less.

COMMISSIONER FIRESTONE: Dr. Kelly, do you have a formula in mind which would take care of this situation, with particular reference to the specific needs of the Province of New Brunswick, and if you don't have that formula at your disposal at the moment, could you include a proposal in your written submission?

DR. KELLY: I think I would like to try it; I think I can.

COMMISSIONER FIRESTONE: Thank you, Dr. Kelly. May I now turn to paragraph 5 on the same page in which you suggest that your experience has been, ".... in services which were initiated under National Health grants becoming a responsibility of the provincial treasury, so that 25 per cent of the grant would remain for new services." Are you in favour of the principle that at least part of the grants be devoted to new services?

DR. KELLY: I am in favour of a segment of the grant but I am not in favour of this large segment. You can see what this is doing: This is forcing our hands sometimes, in a province where it may not be possible to find this money. What it is doing actually is to each year -- and over a period of twelve years or thirteen years this becomes quite a sum of money -- it is forcing us to use 25 per cent of these grants

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COMMISSIONER FIRESTONE: Thank you, sir: That is a specific suggestion which we can consider.

In the last paragraph on page 3 you say that the total of all National Health Grants available to the province for the present year is approximately $1.9 million: What proportion of this amount are you expecting to use during the current year?

DR. KELLY: We are expecting to use at least 95 per cent of this. I might point out here that an administrative problem prevents us from using it all, and this problem is a device emanating from the Department of National Health and Welfare in Ottawa, whereby we must earmark our money in projects for what we

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believe we are going to use it for, and then we are not allowed to make any changes after December 31st. December 31st leaves three full months in our fiscal year, and it is sometimes impossible to tell by December 31st whether you are going to use this $10,000.00 for this, or whether you are not going to be able to get that service into operation. If you don't do it before December 31st, the money must go back to Ottawa. We can't earmark it for any other service.

COMMISSIONER FIRESTONE: In your subsequent submission would it be possible for you to let us have a specific proposal of how you can overcome that administrative difficulty so that the Province of New Brunswick would get 100 cents on the dollar?

DR. KELLY: Yes, I would like to do that. I have made this proposal to Ottawa on several occasions, but they have turned me down.

COMMISSIONER FIRESTONE: As you know, sir, this is an open minded Royal Commission.

DR. KELLY: Thank you.

COMMISSIONER FIRESTONE: May I now turn to section C dealing with mental health, on page 3, the second last paragraph, where you speak of a child guidance service for the mentally ill child as well as the child with behaviour problems, as being both desirable and necessary, and on page 1 of section C in the first paragraph you say that the psychiatric disabilities in the early stages and their treatment before they progress and become chronic is highly desirable. Would you be in favour of a programme to provide for psychiatric

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paragraph you say that the psychiatric disabilities in the early stages and their treatment before they progress and become chronic is highly desirable. Would you be in favour of a programme to provide for psychiatric

examination and other examinations of school children?

DR. KELLY: I would be in favour of a programme for other examinations. I am not qualified, I don't think,to make a decision on the programme of psychiatric examination of school children. I would not like to comment on that aspect of your question. Personally, I would not be in favour of the psychiatric part of the programme for school children. This is my personal view. Now, psychiatrists may have different views on this.

COMMISSIONER FIRESTONE: Are there any plans afoot to provide for examination of school children in the Province of New Brunswick, physical or otherwise?

DR, KELLY: You mean a completely organized plan?

COMMISSIONER FIRESTONE: Yes?

DR. KELLY: No.

COMMISSIONER FIRESTONE: Are there any plans under consideration?

DR. KELLY: No. The only programme we have at the present time is that the public health nursing service go into the schools, but it is left in many cases to the teacher to decide whether this child needs a medical examination, whether this child has defective eyesight or defective hearing and, of course, teachers have so many problems of their own that I don't think this should be their problem.

COMMISSIONER FIRESTONE: Would you consider, sir, in a comprehensive medical care plan

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COMMISSIONER FINNSTONE: Would you consider, sir, in a comprehensive medical [illegible]

examination of school children?

DR. KELLY: Yes, I think it is very important. As I have said in one place in this brief, our children are our greatest asset, and many of us have contributed to society about as much as we are going to contribute, but the children are the contributors of the future, and I don't think any country is strong without healthy children.

COMMISSIONER FIRESTONE: And what would that cover if under a comprehensive medical care plan children were examined at school? What would that cover -- purely their physical health, or if there are any signs of disturbances, somebody would look into the other aspects?

DR. KELLY: I think, just briefly, this should be a screening programme, and any that come out of the screening as indicating further need for health services, then they are directed to the proper channel where the services would be provided.

COMMISSIONER FIRESTONE: That is a very constructive answer, Dr. Kelly, thank you very much. May I now turn to section E dealing with general hospital services. You say in the third paragraph on the first page that you have improved the health services, the hospital services, provided to the people of New Brunswick considerably under the federal-provincial universal hospitalization programme, and you also point out that hospital services now being provided and received by the people of New Brunswick compare very favourably with the national average and indeed exceeds that provided by

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certain other provinces in Canada. Let me ask you this question, sir: Are you satisfied with the operations of this plant?

DR. KELLY: Yes, I believe so. I think we are with the exception -- I do believe that that this plan is going to take some very close scrutiny in the very near future regarding the possibility of costs going out of hand. But certainly in a province where we had 1,288 hospital days per thousand of population before this plan came in and where we are now receiving 1,776 in the last year, after an operation of a year and a half approximately, we couldn't help but be satisfied with this. I believe people were not receiving adequate hospital services, although with the plan being initiated, the people who objected to this type of service, providing this service in this way, all said, most of them remarked, without any basis, of course, that the people of the province were already getting adequate hospital care, what do you want this for? Now, either this was wrong, for instance, or the people were getting too much. Now, I don't believe the people are getting too much. If you go much above this figure in an active treatment hospital programme you are giving the people more than adequate hospital services or, to use to old phrase, you have over-utilization.

COMMISSIONER FIRESTONE: How do you feel about exemptions under this scheme? For example, the way mental health people are treated?

DR. KELLY: I think all health services should be in one package. I don't see why we should look at the mentally ill person or the person who is ill with tuberculosis in any different manner than we look on a person who is ill with cancer or ill with any

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other acute or chronic disease. I am never in favour of differentiating these things. However, it seems expedient at the present time to move segments of health services, and it is possibly a good idea, but it is not a good principle, it doesn't keep uniformity. In this province right now it is difficult for people to tell, when they become ill, who is going to provide the service, no one knows for sure who qualifies. I think it is an excellent thing to have all the health care in one package out of public funds.

COMMISSIONER FIRESTONE: I can see from your observations that you and your colleagues have given some thought as to how the system can be improved in a period of time. Would it be possible to have your ideas in specific terms as to how it could be improved in your subsequent supplementary submission?

DR. KELLY: I would be happy to do so. I don't know what the result would be.

THE CHAIRMAN: You referred to the increase to 1,776 in hospital days. What has been the effect, if any, on the average patient days?

DR. KELLY: There has been a slight increase. When the plan came into effect the average was 8.9 days; from the last statistics I have from hospital service it looked like 10.2 or 10.4.

THE CHAIRMAN: That is a substantial increase?

DR. KELLY: Yes. But you will remember that Saskatchewan went from 10.4 and then they started to go back.

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DR. KELLY: Yes. But you will remember that Saskatchewan went from 10.4 and then they started to go back.

THE CHAIRMAN: What about the maternity rates?

DR. KELLY: I think this is increased by an average of about two days.

THE CHAIRMAN: Have you got the figure? Is it in this 8.9?

DR. KELLY: No. The 8.9 is the whole. I don't have a separate figure here. I would have to get that for you. I think that before the plan came in the average was something like five, and I think it has gone to something like 7. --- I am told it has gone to seven.

COMMISSIONER BALTZAN: Mr. Chairman, in this very same context on the same page, in paragraph 3 :

> "In addition, the hospital facilities provided out-patient insured services to the extent of $308,600.00 to residents of New Brunswick."

My question is, what are these out-patient services?

DR. KELLY: Well, the out-patient insured services referred to here roughly is this: It was emergency out-patient service for accidents if they reported within forty-eight hours, plus a fairly substantial segment of our laboratory service, and I should point out that we are in the process of extending our out-patient services on a much broader basis so that it will include our laboratory service as an insured service, and out-patient service will include electrocardiograms, x-ray diagnostic out-patient. So we know that we will have a much wider out-patient service than any other

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province in Canada. The basis of our thinking is that there are people now occupying beds which would cost $15,000.00 to build and $5,000.00 to operate annually, and in this way we may not have to build so many beds.

COMMISSIONER BALTZAN: Everybody would be entitled to have this service, it is not limited to any specific groups?

DR. KELLY: No, every resident of New Brunswick as defined in the Hospital Services Act and its regulations.

COMMISSIONER BALTZAN: May I just project this one point only. There was mentioned the problem of the physicians distribution and the question of the patient not being able to get to places where there are hospitals and doctors. This would tend to further encourage people to congregate around or to make recourse to hospital services, and it will at the same time discourage physicians from going out of these more sparse areas if that kind of service is needed, and it is useful, but it sort of tends to work against this element of populating the least populated areas.

DR. KELLY: Not if we have a hospital out here, with reasonable facilities for diagnostic work. I mean the average, the average facilities.

COMMISSIONER BALTZAN: These things would tend to encourage physicians to give the modern type of service.

DR. KELLY: We think so.

COMMISSIONER FIRESTONE: Mr. Chairman, I would like to come back to one point. Dr. Kelly,

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when I suggested you might make this information available to us, may I just expand on it -- and we would welcome any contribution which you and your associates may make. The purpose of trying to obtain this information is for the Royal Commission to have an understanding of the problems that the people in the various provinces face, as to how to deal with some of the problems we encounter, so I hope that your co-operation will assist us in understanding the problem in giving us that information.

If I may turn now to section F which deals with child and maternal health services, on page 6 in the first paragraph, you say that drugs for hospital use be bought in quantity by a central provincial purchasing agency. Can you tell us, Dr. Kelly, how does the Province of New Brunswick purchase drugs at the present time?

DR. KELLY: The Province of New Brunswick at the present time leaves the hospital concerned the right to purchase drugs. The only drug therapy we provide on this business is drug therapy for tuberculosis control. These are the drugs which are new no longer, streptomycin, and so on. We purchase these from a central source to our accounting division. All our other hospitals, both those owned and operated by the Department of Health and those owned and operated by other organizations, religious organizations, they purchase them in their own purchasing department, they are not bought from a central supply.

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hospitals which are under provincial control call for tenders in purchasing drugs?

DR. KELLY: I do not believe so. At the present time there are only two mental hospitals, one tuberculosis hospital and one rehabilitation centre, if you want to call it that, that is under provincial control. There are three other tuberculosis hospitals which are not under provincial control and they do not call for tenders as far as I am aware.

COMMISSIONER FIRESTONE: Is your recommendation on page 6 based on the expectation that if there were a central provincial purchasing agency for drugs you may be able to purchase drugs at a lower price?

DR. KELLY: It is more than an expectation. We know the old arrangement which the D.S.C.R., which became the D.V.A., they had a very excellent arrangement where they could purchase drugs in this department for about at least a quarter that the hospital could purchase even from their own government, and if we could have that type of arrangement, I could bring my drug estimates down.

COMMISSIONER FIRESTONE: In view of the views you have just given to us, is the government at present considering the establishment of a central purchasing agency for drugs for the province as a whole covering those institutions which are under provincial public control?

DR. DUMONT: There hasn't been the question brought to study yet, but I should think that as far as the hospitals in general are concerned, all

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over the province, we do believe that it is far better to allow each individual hospital board or through the administrators to look after the buying of their own drugs. Now, for the government institutions we manage along the lines as just described by my friend here, Dr. Kelly. We do have some for the public health immunization, vaccines, and we do buy those centrally, but as far as calling for tenders, there is no official plan yet.

COMMISSIONER FIRESTONE: Thank you. May I now turn to section I dealing with dental health. On page 4 you offer the conclusion:

> "That the best dental care for the citizens of New Brunswick can only be obtained by the establishment of a comprehensive service which may never be wholly adequate but which is equally available to all who demand it and which will be paid for by the community as a whole."

Dr. Kelly, are you applying this principle also to the provision of a general medical care plan as contained in the report?

DR. KELLY: Mr. Chairman, you will notice I haven't made that statement in relation to medical care, although I might say this, that it is my opinion that there are people in this province who are not getting adequate medical care, and the reason they are not getting it is because they don't have the material to purchase it with.

COMMISSIONER FIRESTONE: Now, if I make explore this point a little further. When you are submitting to this Commission the proposal for a general

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COMMISSIONER FIRESTONE: Now, if I make explore this point a little further. When you are

medical care programme you have in mind a comprehensive service similar to what you have recommended in the dental profession, obviously with appropriate changes applicable to the medical profession?

DR. KELLY: Yes.

COMMISSIONER FIRESTONE: Do you have in mind a medical care programme which is equally available to all who demand it?

DR. KELLY: First let me say this. What I have said in this submission and which the Minister has presented, and I have said it on the behalf of the Minister, is what the people of New Brunswick should have is adequate health services. Now, going back to your former question, would you please rephrase it again?

COMMISSIONER FIRESTONE: If you look at page 4, the second paragraph, would you say that a medical care programme should be "equally available to all who demand it" in the Province of New Brunswick?

DR. KELLY: I should take the word "demand" out. I think it should be equally available to all who need it. Certainly we should not make any service in the future sponsored or paid for by public funds available to everybody who demands it; we should make it available to everybody who needs it. Now, the difference between need and demand is quite different here. I think what is wrong all the way along with government-sponsored services in the field of health is that as soon as they become government-sponsored everybody, including sometimes the providers of the service, feel that this is due the person if he demands it. They don't say to

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COMMISSIONER FIRESTONE: Then your suggestion is to change the phrase to equally available to all who require?

DR. KELLY: Yes, require. I think demand is a poor word because this is certainly not true. If we went into anything like this, this would be economic suicide.

COMMISSIONER FIRESTONE: I accept your explanation, thank you. I come now to the last part of the question. Would medical care services on a comprehensive basis be made available to the people of New Brunswick according to these conclusions on the basis of payment of and I quote, "the community as a whole". Is that your recommendation or conclusion?

DR. KELLY: I think the word community as a whole there means the province. It is not my recommendation at all that municipalities should pay, because municipalities in our province do not agree this well.

COMMISSIONER FIRESTONE: But I take it that community as a whole means all the people in the Province of New Brunswick?

DR. KELLY: That is right.

COMMISSIONER FIRESTONE: Plus whatever contributions you can obtain from the rest of Canada?

DR. KELLY: Yes, we must keep this in mind, especially the east here. Our western neighbours, Saskatchewan's former premier made the statement the government does not contribute, he was able to go it alone. We are not in this fortunate position.

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COMMISSIONER FIRESTONE: And coming to section N, Mr. Minister and Dr. Kelly, in which you present us the estimated cost of health services. You are saying under C that it would cost about 12.3 million or $20.00 per capita to provide a comprehensive medical care service plan and then you add about $5.00, more than $5.00, to arrive at $25.00 to include dental care as well. Now, this would then be a comprehensive all-inclusive programme, covering everybody in the Province of New Brunswick, is that correct?

DR. KELLY: Except those excluded by federal and provincial acts and jurisdiction, yes.

COMMISSIONER FIRESTONE: You said a little earlier these are recommendations, these are conclusions which you and your colleagues have arrived at. They are not necessarily an indication of what will happen?

DR. KELLY: No.

COMMISSIONER FIRESTONE: We are not inquiring here as to what will happen. We are interested in your views, the Minister, the Government, the experts, the administraters would feel that such a programme would be a desirable programme for the Province of New Brunswick, and for the people of New Brunswick, provided appropriate arrangements can be made to finance such a programme?

DR. KELLY: Yes.

COMMISSIONER FIRESTONE: Well, that is a clear and direct answer, thank you Dr. Kelly. Have you any suggestions, or any thoughts, or any ideas that you care to make to this Commission at this time, or if

to section N, Mr. Minister and Dr. Kelly, in which you present us the estimated cost of health services. You are saying under C that it would cost about 12.3 million or $20.00 per capita to provide a comprehensive medical care service plan and then you add about $5.00, more than $5.00, to arrive at $25.00 to include dental care as well. Now, this would then be a comprehensive all-inclusive programme, covering everybody in the Province of New Brunswick, is that correct?

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Is a clear and direct answer, thank you Dr. Kelly. Have you any suggestions, or any thoughts, or any ideas that

you feel that you prefer to make this information available to us at a later stage, we will be very happy to have it, and I may pose my question in this way. Assuming that such a programme were developed, how would such a programme be financed: (a) are you in favour of a tax-supported plan; (b) a premium-supported plan; (c) a combination of both, and Dr. Kelly, we are genuinely interested in the view of your government and your officials and we don't want you necessarily to give us a hasty answer, and if you wish to consider the matter carefully, we would be very interested in having your carefully considered views at any time.

DR. KELLY: Yes, I think an item like this needs very careful consideration, in view of my past experience throughout Canada on these things. There is always controversy on matters of financing. Actually, this would have to come from the Minister. I wouldn't mind doing what work I can on it, but this is policy ---

COMMISSIONER FIRESTONE: We appreciate that, and we know that the Minister has good advisers and we are looking forward to getting the Minister's views onthe advice of his advisers.

THE CHAIRMAN: Gentlemen, you have been in the witness box for quite a while. We are very grateful to you for the assistance to the Commission, and again the contents of the brief, and the very willing way in which you have given the information asked from you this morning, and you have been of very, very great assistance to the Commission, and I want to thank you

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again for being here.

THE SECRETARY: This submission will be known as Exhibit 36.

--- EXHIBIT NO. 36: Submission of the Department of Health of the Province of New Brunswick.

THE CHAIRMAN: Now, we will hear from the Victorian Order of Nurses. This will be submission No. 37.

--- EXHIBIT NO. 37: Submission of the Victorian Order of Nurses for the Province of New Brunswick.

SUBMISSION

OF

THE VICTORIAN ORDER OF NURSES
FOR NEW BRUNSWICK

APPEARANCES:

MR. J. E. MURPHY, President

MISS BETTY SEAMAN, Regional Director for the Province of New Brunswick

MR. HAROLD FOWLER, Vice President

DR. W. PRINCE, Vice President.

MISS M. ANDERSON, Secretary

MR. MURPHY: Mr. Chairman and members of the Commission, if I may with your permission present my colleagues. On my left is Miss Betty Seaman, who is the Regional Director of the Victorian Order of

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--- Submission of the Victorian Order of Nurses for the Province of New

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DR. W. PRINCE, Vice President.

MR. MURPHY: Mr. Chairman and members of the Commission, if I may with your permission present my colleagues. On my left is Miss Betty Seaman, who is the Regional Director of the Victorian Order of

Nurses for the Province of New Brunswick. Next is Mr. Harold Fowler, who is Vice President of the New Brunswick Association, and Dr. William Prince, who is also a Vice President, and Miss Margaret Anderson, who is the secretary. My position with the Association is its Vice President.

Mr. Chairman, and members of the Commission, I think I first should say that we are very happy to have this opportunity of putting our picture in New Brunswick for the Victorian Order of Nurses before the Commission. I would propose, with the permission of the Commission to just read the summary, which is on the first page of our submission, and then I would be available for any questioning, and I might say that Miss Seaman would be. I don't know much about the nursing end of the Victorian Order.

SUBMISSION

OF

VICTORIAN ORDER OF NURSES FOR NEW BRUNSWICK

A. SUMMARY

Victorian Order service was introduced in New Brunswick in 1899 with the organization of the Saint John Branch. Eleven branches now serve all cities and seven towns covering 35.4% of the total population in the province. Branch programs in New Brunswick have been planned in relation to those conducted by the provincial Department of Health. The two agencies work co-operatively in an effort to utilize nursing personnel

Nurses for the Province of New Brunswick. Next is Mr. [illegible] who is Vice-President of the Nurses' Association, and Dr. William Prince, who is also a Vice President, and Miss Margaret Anderson, who is the secretary. My position with the Association is its Vice-President.

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to the best advantage and to avoid any overlapping or duplication of service. Consequently, in most branches the Victorian Order provides a generalized public health nursing program in addition to the usual bedside nursing program.

The business affairs on the local and provincial level are conducted by boards of management. The generous support of these voluntary board members not only creates interest in Victorian Order services, but is also a contributing factor in making Victorian Order costs so moderate.

I might say that this brief was necessarily prepared by the nursing staff, or by the executive of the nursing staff, and it became my function to read it, so it is they who are talking of the general support.

Victorian Order branches, particularly in small communities, have been greatly assisted by donated facilities such as office accommodation and furniture, telephone answering service and cars.

As long as there is a need for Victorian Order service an effort will be made to find ways and means of financing it.

I might say here that an effort will be made, but I would not wish the Commission to get the idea that the effort is easy.

However, since hospital insurance, with no premium, is available to all citizens there appears to be a reluctance on the part of many patients to pay for care at home. If payment for nursing care in the home

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were available through some form of pre-payment, the Victorian Order could be of increasing assistance in relieving pressure on hospitals and in further developing visiting nursing care for all patients who can be cared for at home. If funds were available the Victorian Order could extend its services to areas not now being served and particularly to those areas adjacent to existing branches. Services such as hospital referral programs could be developed.

The Victorian Order is willing to experiment in new programs and to cooperate in any program which will strengthen and co-ordinate health services in New Brunswick.

THE CHAIRMAN: Is there any further comment that you would like to make at this time, Miss Seaman or Mr. Fowler, or Dr. Prince, Miss Anderson?

Taking the hospital programme, the universal hospital programme, which is now available to every resident of New Brunswick, as a pattern, if you had medical service, I mean a complete health programme, similarly available, are you able to say what would be the function of a voluntary organization such as yours in that future, if it should come about?

MISS SEAMAN: I believe, sir, that it would still have a place in caring for any illness at home, because for many patients recovery is more rapid and rehabilitation is more quickly attained in their own home surroundings, and the voluntary agency has as one of its purposes to demonstrate new programmes. We might find our place through demonstration, visiting services,

relieving pressure on hospitals and in further developing visiting nursing care for all patients who can be cared for at home. If funds were available the Victorian Order could extend its services to areas not now being served and particularly to those areas adjacent to existing branches. Services such as hospital referral programs could be developed.

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or added services in the Victorian Order under a programme of health insurance .

THE CHAIRMAN: Your brief implies that you are finding, shall we say a resistance, to paid for nursing care in the home vis-a-vis free hospitalization in the hospital. Just how noticeable is that?

MISS SEAMAN: It is fairly obvious in a great many cases that a person feels that if they are getting a service for nothing, why should they come home and pay for it. It is human nature I suppose.

THE CHAIRMAN: But you are finding that as a factor?

MISS SEAMAN: I think so, sir.

MR. MURPHY: I might say, Mr. Chairman, to answer the other side of this order. From our viewpoint we find that it is becoming more difficult to get money donated for the reason that the people who normally support these organizations now don't understand why they have to have the V.O.N., because they assume that anybody who is sick can go to the hospital and be looked after. Of course, that is not the case, but I think that in any place if a person can save money, that is, not give it away, that he will find an excuse or a reason for keeping it, and we are running into that trouble.

THE CHAIRMAN: I take it you are not saying that as applying only to the V.O.N.?

MR. MURPHY: No, no.

THE CHAIRMAN: That is a common condition?

MR. MURPHY: I think it would apply

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to the V.O.N. more than, say, the Red Cross. Well, the Red Cross is a bad example, or some other agency which is not in health matters. To the boy scout movement.

COMMISSIONER GIRARD: Mr. Chairman, I would like to come back, if Mr. Murphy or Miss Seaman does not see anything wrong with this, coming back to a statement in the Ministry of Health brief, and trying to apply it here. A paragraph on page 5, section 4, says:

> "It has been specified elsewhere that the link between the community and the hospital nurse should be strengthened".

If we take V.O.N. as a community organization, and take into account that there was also mentioned a need of 45 more health nurses in New Brunswick, are there any areas where the V.O.N. could be of some specific help in aiding to fulfill ~~this need?~~

MISS SEAMAN: I think we can be of considerable assistance in that area to hospital referral programmes, one of which has been initiated here and in operation for nearly a year, and this helps by bringing information regarding our service to the patient, and to the hospital personnel, and also interpreting to the patient the care they can get in post-hospital treatment.

COMMISSIONER GIRARD: This experiment with the Moncton City Hospital, do you feel that it is reaching the need for which it was started, and do you feel that it should continue?

MISS SEAMAN: It seems to be progressing very satisfactorily. It is a little bit too early to tell how much it has been doing, but it has been doing very well.

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The business affairs on the local and provincial level are conducted by boards of management. The generous support of these voluntary board members not only creates interest in Victorian Order service, but is also a contributing factor in making Victorian Order costs so moderate. Victorian Order branches, particularly in small communities, have been greatly assisted by donated facilities such as office accommodation and furniture, telephone answering service and cars.

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The Victorian Order is willing to experiment in new programs and to cooperate in any program which will strengthen and coordinate health services in New Brunswick.

B. PRESENT FACILITIES

1. Area Served

The eleven branches of the Victorian Order of Nurses in New Brunswick provide nursing care and health supervision in all cities and in seven towns. These branches serve a population of 202,416 or 34.3 per cent of the total population of the province (based on an estimated population of 590,666 for 1959). The 1960 Annual Report of the Department of Health of New Brunswick indicates the total urban population to be 208,880. Since Victorian Order branches are located in urban areas it may be concluded that service is

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available to 94.6 per cent of the urban residents of the province.

Branches are located in Bathurst, Campbellton, Edmunston, Fredericton, Moncton, Newcastle, Sackville, Saint John, Oromocto and Woodstock. Saint John also serves the city of Lancaster and several other branches extend their boundaries to include surrounding communities. Saint John, the oldest branch in the province, was opened in 1899. Oromocto, the youngest branch, inaugurated service in January 1960.

2. Organization

The business affairs of each branch are conducted by a local board of management composed of representative citizens elected at the annual meeting. Members of these boards are allocated to committees who look after the various board responsibilities such as finance, transportation, publicity. The members of the local boards of management give freely of their time and efforts to provide Victorian Order service in their communities. This is a contributing factor in making Victorian Order costs so moderate.

There is a medical advisory committee in each branch, the members of which act in a consultant capacity to the nurses. The support of the busy doctors who act on these committees is invaluable and the resulting close working relationship which develops between doctor and nurse makes for better and more understanding patient care.

The provincial association was organized in 1957. The association is composed of the board members

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from the eleven branches in the province and a representative from the Victorian Order of Nurses for Canada. Its Board of Management is composed of the elected officers; one representative from each local branch and the regional director in an ex-officio capacity. Provision is made for an advisory board consisting of the Chief Medical Officer of the Department of Health, a representative of the provincial medical association, a representative of the provincial registered nurses' association and the Director in Chief of the Victorian Order of Nurses for Canada.

There is free exchange of information and assistance between the provincial Department of Health and the Victorian Order of Nurses at all levels. The nurses on the staffs of both agencies work in partnership in the health educational phase of the service, the rehabilitation program, the immunization program and any special project carried out by the Department. Care is taken to avoid duplication of service. Close contact is maintained with the hospitals within the areas served to facilitate the transfer of patients needing continued care and health supervision on discharge from hospitals.

3. Program

In 1961, skilled nursing care and health supervision on a part-time basis was given to 10,865 patients, the total number of visits being 64,719. This is an increase over the previous year of 30 per cent in the number of patients and 11 per cent in the number of

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visits. The marked increase in service during 1960 was partly accounted for by the opening of a new branch in January of that year. However, over a five-year period there has been a steady growth in service. Although mothers and babies accounted for almost two-thirds of the patients, one-half of all visits were made to patients with medical and surgical conditions. An analysis of the age groups of patients served indicates that the bulk of Victorian Order service is given to those under fifteen years of age and over sixty-five. More detailed information on service is given in Appendix I.

From records of medical and surgical patients dismissed from Victorian Order care in 1960, 27.6 per ent had been in hospital before receiving visiting nursing service. To provide for continuity of care from hospital to home a formal referral program has been inaugurated in Moncton whereby a Victorian Order nurse spends part of each day in the Moncton City Hospital. Similar, though less formal programs, have been set up in two other branches. These services have been undertaken by the Victorian Order in a co-operative effort with the hospitals to demonstrate their value.

Two branches provide part-time industrial health services in three plants which are not large enough to require a full-time nurse. These branches are compensated in full for the services rendered in the plants.

The development of the branch programs in New Brunswick was influenced by the fact that the Victorian Order gave service to many communities before the

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provincial Department of Health provided a public health nursing service. For many years the branches have been subsidized by the Department fo carry out the official agency activities within their area. In an effort to utilize nursing personnel to the best advantage and to avoid duplication and overlapping of services, the Victorian Order was encouraged to continue to provide these public health nursing services. As a result in eight branches a generalized public health nursing program is undertaken. In the remaining three, the Order conducts prenatal and postnatal classes and child health conferences in addition to the visiting nursing program.

During 1960 in line with Victorian Order policy to assist in the preparation of well qualified nurses, eleven public health nursing students from university schools of nursing received a three-week period of field experience in New Brunswick. Also, 197 students from eleven hospital schools of nursing had observation experience.

4. Personnel

The eleven branches in New Brunswick employ a total of forty-one nurses. Of these, fifteen have public health nursing qualifications and one of these has advanced preparation in administration and supervision at the degree level. Of the nurses having public health nursing qualifications, thirteen completed their preparation with the assistance of bursaries from the Victorian Order of Nurses for Canada, one received a bursary from the provincial Department

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of Health, and one financed her own education independently. Relief nurses are used when necessary.

The Order encourages the nurses to attend institutes which are held from time to time both at the University of New Brunswick and at Dalhousie University in Halifax. These provide opportunities for refresher courses or continued education along various lines of service. The provincial Department of Health has assisted the Order in covering the expenses incurred in attending these institutes.

5. Office, Telephone and Transportation

The provision of suitable office facilities, telephone answering service and adequate transportation is the responsibility of the local boards of management.

Office facilities are supplied in six branches free of charge in public buildings such as town halls, schools or fire halls. The five remaining branches have offices for which rent is paid, in business or professional establishments. In nine of the eleven branches in New B unswick arrangements have been made so that the telephone answering service is covered free of charge by hospitals, police stations or fire halls. Two branches use commercial telephone answering services. A total of twenty-eight cars are operated in New Brunswick, twenty-five of which are branch-owned. The number of cars in a branch depends on the size of the branch and the type of public transportation available in the community. Each branch has at least one car.

6. Finances

In 1960, $170,691.00 was raised to support

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Victorian Order service in New Brunswick. This was done in the following ways:

(a) Municipal grants varying in size from $1,000 to $26,000, depending on the size of the branch and services provided, were received in each branch. These amounted to 47 per cent of the total amount.

(b) The provincial Department of Health furnished grants direct to all branches. These amounted to $30,125 or 21 per cent of the total income. The grants vary according to number of nurses employed in each branch, The scale is as follows:

A one nurse branch received $1,500

A two nurse branch received $1,500 for the first nurse; $1,000 for the second nurse

A three nurse branch received $1,500 for the first nurse; $1,000 for the second nurse; $500 for the third nurse

Larger branches received $250 for each additional nurse over and above the first three nurses.

(c) Money received from nursing fees totalled $23,765 or 14 per cent of all income. The fee charged the patient is based on actual cost to the branch. Costs in the eleven branches inNew Brunswick varied from the lowest of $1.93 to the highest $3.11 per visit. Although a fee is charged for nursing service, care is provided even though the patient is unable to pay for it. Consequently many visits are either part-paid or

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(d) The remaining amount, 18 per cent of the total, was raised by appeals to the public and other sources in the various communities. Three branches are members of united appeals or community chests and the remaining eight conducted their own campaigns. Included in this amount is payment for part-time industrial health services provided in two of the branches. Income from this source amounted to one per cent of total provincial income. Total disbursements in 1960 amounted to $163,114. The largest item included in this amount was salaries which accounted for 78 per cent of the total. Other amounts were transportation and related expenses 10 per cent; office supplies and upkeep 4 per cent; and general expenses, including nursing supplies, insurance, pension contributions, etc. 8 per cent.

Each branch has an audited statement of receipts and disbursements. A summary on a provincial basis for 1960 is included in Appendix II

C. FACTORS AFFECTING VICTORIAN ORDER SERVICE

In New Brunswick there is no premium for hospital insurance. As hospital care is available through insurance there appears to be a reluctance on the part of many patients to pay for nursing care in the home. Consequently it is felt that if payment for nursing care in the home were available through some

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form of prepayment, the Victorian Order could be of increasing assistance in relieving pressure on the hospitals.

One problem which faces the Victorian Order in common with other nurse-employing agencies, is the difficulty in obtaining fully qualified staff. There is a shortage of nursing personnel in all fields but particularly in the areas in which special preparation is necessary. Without the services of those who have received bursary assistance either from the Victorian Order of Nurses for Canada or the provincial Department of Health, it would be practically impossible to staff the branches.

Information as to the services provided by the Victorian Order of Nurses is disseminated on a national level through magazine articles, press releases and the provision of television publicity. At the local level, programmes designed to interpret Victorian Order service are carried out intensively during the rest of the year. The press, radio and television stations give generous assistance in all publicity efforts. Continued interpretation of service is essential if the fullest use is to be made of the facilities available.

D. POSSIBLE EXTENSION OF SERVICE

The two requirements for establishing a branch of the Victorian Order are a need for service and financial support. Although no study has been made as to the possibilities of extending to the rural areas, a greater contribution to the health services of the

increasing assistance in relieving pressure on the hospitals.

One problem which faces the Victorian Order in common with other nurse-employing agencies, is the difficulty in obtaining fully qualified staff. There is a shortage of nursing personnel in all fields but particularly in the areas in which special preparation is necessary. Without the services of those who have received bursary assistance either from the Victorian Order of Nurses for Canada or the provincial Department of Health, it would be practically impossible to staff the branches.

Information as to the services provided by the Victorian Order of Nurses is disseminated on a national level through magazine articles, press releases and the provision of television publicity. At the local level, programmes designed to interpret Victorian Order service are carried out intensively during the rest of the year. The press, radio and television stations give generous assistance in all publicity efforts. Continued interpretation of service is essential if the fullest use is to be made of the facilities available.

The two requirements for establishing a branch of the Victorian Order are a need for service and financial support. Although no study has been made as to the possibilities of extending to the rural areas

province could be made through extension to areas immediately adjoining the established branches. In recent years several branches have enlarged the area served and at the present time, four branches are seriously considering extending their boundaries to include adjacent communities. As the need for service is evident, ways and means of financing the undertaking are being studied. One of the difficulties encountered is the securing of financial support from the county authorities when only a portion of the county area will be served.

In addition to extension of territory, present services such as hospital referral programs, might be expanded and developed if funds were available.

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In addition to extension of territory, present services such as hospital referral programs might be expanded and developed if funds were available.

APPENDIX I

Statistical Analysis of Visiting Nursing Service

The two methods of obtaining statistical information has been described in the preliminary statement submitted by the Victorian Order of Nurses for Canada. The following analyses are based on selected data compiled by both methods for the year 1960. The data quoted from the Dominion Bureau of Statistics for 1960 are preliminary and have not yet been published.

TABLE I

NUMBER OF CASES AND VISITS BY YEAR

Year	Cases	Visits
1956	7,299	52,452
1959	8,172	58,256
1960	10,865	64,719

Source: Victorian Order of Nurses for Canada, Branch Statistics.

Table I shows a comparison of total cases and visits for 1956, 1959 and 1960. In 1960, 64,719 visits were made to 10,865 patients, an increase over the previous year of 2,693 patients or 30 per cent and of 6,463 visits or 11 per cent. This increase is partly accounted for by the opening of a new branch in January. However, comparative figures for the past years indicate a steady growth in service. Since 1956 there has been an increase of 48.9 per cent in cases and an increase of 23.4 per cent in visits.

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TABLE II

NUMBER OF CASES AND VISITS BY TYPE FOR 1960

Type	Cases	%	Visits	%
Maternity & Newborn*	6,948	64.	17,112	26.
Medical & Surgical	3,917	36.	32,132	50.
Health Instruction			13,052	20.
Infant			8,315)	
Preschool			1,074)	(16.9)
School			1,565)	
Adult			2,098	
Other visits **			2,423	4.
TOTAL	10,865	100.	64,719	100

* Newborn: age 28 days or less. Visits include 7,427 for health instruction.

** Patients not seen. On behalf of patient.

Source: Victorian Order of Nurses for Canada, Branch Statistics 1960.

Table II shows total cases and visits by type. While 6,948 patients or 64 per cent were mothers and babies only 26 per cent of the visits were made to this group. 32,132 visits or 50 per cent were made to patients with medical and surgical conditions. Because of the nature of the services given in New Brunswick, health counselling services are provided for infant, preschool and school age children. These visits accounted for approximately 17 per cent of the total.

From data compiled by the Dominion Bureau of Statistics on cases dismissed from Victorian Order service in 1960 further detail is available on a provincial basis particularly in relation to patients with medical or surgical conditions. Patients in this

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Type			Visits	
Maternity & Newborn*	6,948	64.	17,112	26.
Medical & Surgical	3,917	36.	32,132	50.
Infant			6,3[illegible]	
School			1,[illegible]	
TOTAL	10,865	100.	64,719	100

* Newborn: age 28 days or less. Visits include 7,427 for health instruction.

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group include those of all age groups and with any type of medical or surgical condition, acute or chronic. From cases dismissed in 1960, 2,310 patients with these conditions had received 32,702 visits.

TABLE III

NUMBER OF MEDICAL AND SURGICAL CASES AND VISITS BY AGE GROUP

Age	Cases	%	Visits	%
Under 15	1,028	44.5	4,284	13.1
15 - 44	343	14.9	2,957	9.1
45 - 64	252	10.9	4,619	14.1
65 and over	687	29.7	20,842	63.7
TOTAL	2,310	100	32,702	100

Source: Dominion Bureau of Statistics from Medical and Surgical cases dismissed by the Victorian Order of Nurses in 1960.

Table III shows the distribution of these medical and surgical patients and visits by age group. This table indicates that three-quarters of the patients were either under 15 years or over 65 years of age. It is significant that 63.7 per cent of all visits were made to patients in the older age group.

27.6 per cent of all medical and surgical patients were admitted after discharge from hospital and they received 30.1 per cent of the total visits.

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Age	Cases	%	Visits	%
Under 15	1,028	44.5	4,224	13.1
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45 - 64	252	10.9	4,629	14.1
65 and over	657	28.7	20,842	63.8
TOTAL	2,310	100	32,702	100

Source: Dominion Bureau of Statistics from Medical and Surgical cases dismissed by the Victorian Order of Nurses in 1960.

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This table indicates that three-quarters of the patients were either under 15 years or over 65 years of age. It is significant that 63.7 per cent of all visits were made to patients in the older age group.

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TABLE IV

NUMBER OF MEDICAL AND SURGICAL CASES AND VISITS BY DURATION OF SERVICE

Duration of Nursing Service	Cases	%	Visits	%
Under 1 month	1,347	58.3	4,204	12.8
1 - 3 months	459	19.9	3,496	10.7
3 mos. to 1 year	370	16.	7,645	23.4
1 year and over	134	5.8	17,357	53.1
TOTAL	2,310	100	32,702	100

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

Table IV shows the duration of service in terms of cases and visits. It indicates that 58.3 per cent of all patients required service for less than one month. 5.8 per cent had Victorian Order service for more than one year but these patients received 53.1 per cent of the total visits.

From data relating to the cause of illness which is classified under 25 cause groups, patients received care for all types of illness. 595 patients or 25 per cent were admitted for diseases of the respiratory or digestive systems. 938 or 40 per cent were included in the eight cause groups usually considered to be chronic in nature, namely, malignant neoplasms, diabetes, anemias, diseases of the central nervous system, arthritis and rheumatism, senility and ill-defined causes. Table V, on the following page, shows that over 62 per cent of all medical and surgical visits were made to patients in these eight categories. In these groups 83 patients had received service over 1 year and of these 20 had been cared for more than 3 years.

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Duration of Ser-vice	Number	%	Visits	%
1 - 3 months	459	19.9	3,496	10.7
3 mos. to 1 year	370	16.	7,645	23.4
1 year and over	1,481	64.1	21,561	65.9
TOTAL	2,310	100	32,702	100

Source: Dominion Bureau of Statistics "Medical and surgical cases diagnosed by the Veterans Bureau of Canada in 1923."

Table IV shows the duration of service in terms of cases and visits. It indicates that 19.3 per cent of all patients required service for less than one month. 3.8 per cent had Veterans Bureau service for more than one year but these patients received 33.1 per cent of the total visits.

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TABLE V

DURATION OF NURSING SERVICE FOR 8 CAUSES OF ILLNESS (CHRONIC)

BY CASES AND VISITS

CAUSES	UNDER 1 MONTH		1 MONTH UNDER 1 YEAR		1 YEAR AND UNDER 2		2 YEARS AND UNDER 3		3 YEARS AND OVER		TOTAL	
	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits
ALL CAUSES	1,347	4,204	829	11,141	78	5,522	27	2,350	27	9,485	2,308	32,702
Malignant Neoplasms	45	199	29	619	2	164	1	48	1	205	78	1,235
Diabetes	42	219	22	1,067	4	1,235	-	-	2	372	70	2,893
Anemias	29	184	83	1,444	14	1,229	7	402	8	2,031	141	5,290
Central Nervous System	107	392	101	1,048	7	416	4	389	3	1,255	222	3,500
Diseases of Heart	35	132	39	1,083	7	716	2	229	2	1,305	85	3,465
Other Diseases Circulatory System	17	93	17	624	2	110	1	13	2	528	39	1,368
Arthritis & Rheumatism	13	24	11	118	3	155	-	-	1	35	28	332
Symptoms, Senility, ill-defined conditions	174	435	91	1,138	8	413	1	115	1	301	275	2,402
TOTAL	462	1,678	393	7,141	47	4,438	16	1,196	20	6,032	938	20,485

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

TABLE V

DURATION OF NURSING SERVICE FOR 8 CAUSES OF ILLNESS (CHRONIC)

BY CASES AND VISITS

	Cases	Visits	Under 2 Cases	Under 2 Visits	Under 5 Cases	Under 5 Visits	Over Cases	Over Visits	TOTAL Cases	TOTAL Visits
ALL CAUSES										
Malignant neoplasms	42	219	22	1,057	4	1,235	-	-	2	372	70	2,859
Hearts	25	184	83	1,444	14	1,229	7	402	5	4,021	141	5,299
Other	107	392	101	1,448	7	416	4	389	3	1,257	222	3,500
Other heart of Acute	35	108	39	1,002	7	704	3	229	2	1,305	85	3,465
	17	93	17	624	2	110	1	17	2	528	39	1,394
	13	46	1	116	1	109	-	-	1	35	25	336
Hypertonic, Scleroses	174	4 5	91	1,[illegible]	5	410	1	14	1	301	277	2,402
TOTAL	452	[illegible]	[illegible]	[illegible]	47	4,238	16	1,080	16	3,022	756	20,245

Over Two Years of Chronic [illegible] Nursing [illegible] Under Supervision [illegible] 1 [illegible] for Cases

APPENDIX II

1. SUMMARY OF GENERAL RECEIPTS FOR THE YEAR 1960 IN NEW BRUNSWICK

NURSING FEES	
Patients	$23,253.00
Other *	512.00
GRANTS	
Municipal	80,033.00
Provincial	30,125.00
Other **	5,000.00
COMMUNITY APPEALS	
Community Chest	12,979.00
Branch Campaigns	14,284.00
OCCUPATIONAL HEALTH SERVICE	1,341.00
INCOME FROM SECURITIES AND INVESTMENT	410.00
MISCELLANEOUS	
Donations, gifts, etc.	2,754.00
TOTAL RECEIPTS	$170,691.00

* Other includes payment from contracts with Department of Veterans Affairs

**Other includes grants from school boards, insurance companies and cancer clinics

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SUMMARY OF GENERAL RECEIPTS FOR THE YEAR 1950
IN NEW BRUNSWICK

NURSING FEES

Patients

GRANTS

Municipal

AND INTERMUNICIPAL

* Other includes payment from contracts with Department of Veterans Affairs

2. SUMMARY OF GENERAL DISBURSEMENTS FOR THE YEAR 1960 IN NEW BRUNSWICK

Salaries (before tax and other deductions)	
Nursing staff	$123,264.00
Other	4,374.00
Transportation Expenses	11,568.00
Rent and Related Expenses	3,559.00
Nursing Supplies & Equipment	964.00
Office Expenses *	3,171.00
General Expenses **	10,179.00
Miscellaneous Expenses	691.00
Sundry (unspecified)	407.00
Capital Disbursements	
Automobile purchase payments	2,596.00
Furniture & Office Equipment	400.00
Transferred to Car Depreciation Reserve Account	1,300.00
Loans repaid, bonds purchased, transfers to other special accounts	641.00
TOTAL DISBURSEMENTS	$163,114.00

* Among items included under Office Expenses are the following: Express; Inspection and Repair; Office Equipment; Nursing Forms and Records; Postage; Printing and Stationery; Telephone and Telegraph (including answering service).

** Among items included under General Expenses are the following: Advertising and Oublicity; Annual Meeting Expenses; Auditing,Bank Charges and Exchange; Dues and Subscriptions; Insurance - Staff accident, sickness - Employers' Liability, Workmen's Compensation, etc.; Laundry; National Professional Service Charge; Nurses Health Examinations; Post Office Safety Deposit Boxes; Refresher Courses; Pension Plan - Branch Contributions; Uniform Allowance.

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Salaries (before tax and other deductions)	
Nursing staff	$129,204.00
Other	4,394.00
Transportation Expenses	11,962.00
Rent and Related Expenses	3,750.00
Nursing Supplies & Equipment	964.00
Office Expenses *	3,172.00
General Expenses **	10,172.00
Sundry (unspecified)	401.00
Capital Disbursements	
Automobile purchase payments	[illegible]
Furniture & Office Equipment	[illegible]
Trans. owed to Car Depreciation Reserve Account	3,200.00
Loans repaid, bonds purchased, transfers to other special accounts	964.00
TOTAL DISBURSEMENTS	$167,114.00

* Among items included under Office Expenses are the following: Expense; Inspection and Repair; Office Furniture; [illegible]; Printing and Stationery; Telephone and Telegram (including answering service).

** Among items included under General Expenses are the following: Advertising and Gratuity; Bonus; Meeting Expenses; [illegible]; [illegible]; and Subscriptions; Insurance - Staff accident, alcohol - Employers' Liability, Workmen's Compensation, etc.; Laundry; Medical [illegible]; Nursing Service Nurses Health Examinations; Post Office Safety Deposit Boxes; Refresher Courses; Public Relations - Branch Contributions; Uniform Allowance.

COMMISSIONER GIRARD: May I ask another question, and this also applies to some of the things we have heard before this morning. Has any thought been given to nursing assistants in public health nursing services, in view of shortages that have been talked about? You are answering for your agency, or course?

MR. CONNER GERRARD: May I ask another question, and this also applies to some of the things we have heard before this morning. Has any thought been given to nursing assistants in public health nursing services, in view of shortages that have been talked about? You are answering for your agency, or

MISS SEAMAN: We have used nursing assistants in larger centres to fill certain requirements. It is felt, however, in several of the branches that we have in this province that it would not be economic, and there would be insufficient work that they would be equipped to do, and again it is felt that maybe a nurse needs more background in dealing with certain kinds of situations, and in order to take complete care of her patients she needs to have more knowledge.

COMMISSIONER BALTZAN: I have just one question, Mr. Chairman. I would like to put it to Mr. Murphy, and it is in your second paragraph on page 1:

> "The generous support of these voluntary board members not only creates interest in Victorian Order service but is also a contributing factor in making Victorian Order costs so moderate."

We hear that so much about voluntary organizations, and I am very delighted that this always is the case with regard to the Victorian Order of Nurses. You may want to answer this, or you may help me to understand, and my question is, what is the factor which makes it possible for voluntary organizations to render services at reduced costs, or, as you say, moderate costs? Is it because of the administrative factors, or is it because of certain economical factors which voluntary organizations seem to have?

MR. MURPHY: Mr. Commissioner, I would like to know the answer to that. I know it is a fact, but why, I have my suspicions. I might tell you how I became associated with the V.O.N. Some years ago, in

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MR. MURPHY: Mr. Commissioner, I would like to know the answer to that. I know it is a fact, but why, I have my suspicions. I might tell you how I became associated with the V.O.N. Some years ago, in

1947 or 1948, the V.O.N. was established in Moncton and it came each year to the city council for a grant. I must say with some shame that the council paid very little attention to it. We felt it was another organization which was looking to the city for funds, that it was not doing any particular -- when I say "we", that is the way I felt; I happened to be head of the council in 1947. So, we thought we might cut out the grant and perhaps do away with the V.O.N. I had a very able city clerk at the time, and he came into the office and he said, "Do you realize if we dispose of the V.O.N., which is costing us $8,000.00 or $9,000.00 a year, that we will have to provide that service?" He had a budget made out -- "and it is going to cost us $20,000.00 to $22,000.00, and naturally, it is going to expand."

I think the reason is this though: When the service is voluntary, the general public are satisfied with the service that is given, which is generally adequate, but when it is government sponsored -- that is, either by the town or the province -- the people demand a lot more, and the politicians will give them a lot more and that is the reason the cost increases. They get more than adequate services.

COMMISSIONER McCUTCHEON: I take it following what you have just said you would go so far as to say if the province withdrew its grant, which amounted last year to about 21 per cent of the total income, that it may cost the province more than $30,000.00 a year to provide the service?

MR. MURPHY: I am satisfied with that

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We have forty-one nurses in the province, and the total budget is in the brief here. I am not too familiar with it. I am satisfied if these services were being provided by the province, and if the province was doing it as efficiently as it could be done, it would cost twice as much.

THE CHAIRMAN: Thank you very much, Mr. Murphy.

MR. MURPHY: There is one more thing I would like to say in answer to your first question which Miss Seaman answered. I would like to supplement it: Your question as to whether there is a place for the full voluntary organization in a comprehensive health plan. My feeling on that is -- and I think it is the feeling of most members of the various boards of management -- that a voluntary organization provides certain, for the want of a better term, "warmth", when you are dealing with people and patients such as nurses have to deal with, that is absent when the organization is a governmental agency. We have and I have the utmost respect for the nurse who is a civil servant, but it seems to me, and I have heard patients say this -- well, they are happy to see the V.O.N. come. They like the public health nurses, but it follows that if a person is in the civil service -- let me put it this way: The girls that we get to act as nurses in the V.O.N., especially in New Brunswick, generally are not receiving as much money as their counterparts in the hospitals and in the Department of Health. They have a more difficult job. They have to take responsibility which the hospital nurse does not have

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to take. All of their care is in homes, and many of the homes are anything but attractive. Yet, although we have some trouble getting them, we have forty-one nurses in New Brunswick, and I would say there must be a certain dedication, a certain feeling that these nurses must have to do the work, because it is the least attractive of all the nursing services, and yet they stay with it. Some of them stay with it for ten, twelve and fifteen years and longer. So, when you have that type of person -- and I want to be very careful because I don't want to hurt the feelings of the general nursing group -- but when you have that type of person, the patient is going to get some psychological treatment or some treatment which will affect the patient psychologically and assist him to get better. I think it would be a terrible shame if this voluntary organization, or any voluntary organization, including St. Johns, and this one, were to be dispensed with.

THE CHAIRMAN: Thank you very much, Mr. Murphy, and your delegation.

The Maritime Hospital Service Association.

SUBMISSION

OF

THE MARITIME HOSPITAL SERVICE ASSOCIATION

APPEARANCES:

Mr. JOHN N. FLOOD, Chairman

MR. W. R. FISKE, Vice-chairman

MR. J. A COMEAU, Trustee

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THE CHAIRMAN: Thank you very much Mr. Murphy, and your delegation.

APPEARANCES:

MR. W. R. FISHER, Vice-chairman

MR. J. A DONEAU, Members

MR. M. A. FARMER, Q.C., Trustee

MR. J. A. MacDOUGALL. M.D., Associate Director in charge of professional relations.

MR. W. W. B. DICK, C.A., Of the auditors to the Association

MR. T. L. DOYLE, Executive Director and Secretary-treasurer.

MR. FLOOD: Mr. Chief Justice Emmett Hall, Chairman of the Royal Commission on Health Servies: Mr. Chairman and Members of the Royal Commission. My name is John Flood, a construction engineer from Saint John. I am appearing here today on behalf of and as Chairman of the Board of Trustees of the Maritime Hospital Services Association - Maritime Blue Shield - Blue Cross. I would like to introduce the other members of our delegation --

Mr. W. R. Fiske, Purchasing Agent, Lockhard Woodworkers Limited of Moncton, Mr. Fiske is Vice Chairman of our Board of Trustees.

Mr. J. Alphonse Comeau, School Inspector from Meteghan River, N.S.

Mr. M. Alban Farmer, lawyer from Charlottetown, and member of the P.E.I. Legislature.

Mr. Comeau and Mr. Farmer are members of the Board.

We also have with us Mr. T. L. Doyle, the Association's Executive Director and Secretary-Treasurer; Dr. J. A. MacDougall, Associate Director in charge of Professional Relations; and Mr. W. W. B. Dick, C.A., of Hudson, McMackin Company of Moncton, Auditors to the Association.

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MR. FLOOD: Mr. Chief Justice Kennedy, Hall, Chairman of the Royal Commission on Health Ser

Mr. Chairman and Members of the Royal Commission

My name is John Flood, a construction engineer from Saint John. I am appearing here today on behalf of and as Chairman of the Board of Trustees of the Maritime Hospital Services Association - Maritime Blue Shield - Blue Cross. I would like to introduce the other members of our delegation --

Mr. W. R. Blake, Purchasing Agent, Canadian Woodworkers Limited of Moncton. Mr. Blake is Vice Chairman of our Board of Trustees.

Mr. J. Alphonse Comeau, School Inspector from Meteghan River, N.S.

Mr. M. Alban Farmer, lawyer from Charlottetown and member of the P.E.I. Legislature.

Mr. Comeau and Mr. Farmer are members of the Board.

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MacDougall, Associate Director in charge of Professional Relations; and Mr. W. W. B. Dick, C.A., of Hudson, McMaster Company of Moncton, Auditors to the Association.

This letter I am going to read to you, Mr. Chairman, is not a summary of the brief necessarily, but it is going to outline some of the philosophy behind the proposals in our brief and the statement in it, and it is not necessarily a repetition of the thing, but it does involve reference to certain portions of the brief in order to explain the philosophy.

Mr. Chairman, you and your Commission have had an opportunity to review the brief from the Maritime Hospital Service Assocition.

As we stated in that brief it has been our concern over the years to do our part in making health care available to all who need it. We have indicated also our belief that every family in the Atlantic Provinces should have available to it the means of protection against the cost of adequate medical care. We have outlined the progress we have made in attaining that goal. Research is necessary, if a satisfactory level of medical care is to be made available to everyone.

It is recognized that all levels of government - federal, provincial, municipal - have shown increasing interest in the health needs of the people. We commend the decision to have a Royal Commission make a searching investigation of every facet of the question of the health needs of our people and how best to provide for them. It is our hope that out of your studies you will make recommendations which will lend assistance and support to the voluntary non-profit plans - which aid in necessary if a satisfactory level of medical care is to be made available to everyone.

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Much credit for the success attained by MHSA can be attributed to five factors:

1. Soundness of purpose - MHSA was created to help all the people of this area solve their own health care financing problems. Providing this type of protection continues to be our only business.

2. Dedication of Board members - The Board of MHSA is

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composed of representatives of government, the subscribing public, the medical profession, and member-hospitals. They serve without pay and are dedicated to guiding the Association in the best interests of both the recipient and provider of services.

3. Management and labor interest in the subject of health care in their capacities as employers and leaders in the communities in which they live and do business. It is quite common for a union to designate Blue Shield - Blue Cross as the provider of surgical-obstetrical-medical and hospital care, recognizing that through the provision of service type benefits in preference to indemnity benefits union members are obtaining the maximum in health benefits. Management's interest and approval is evidenced in a great many instances by the readiness to make a contribution towards membership costs as encouragement to their employees to participate.

4. Medical sponsorship has contributed much to the success of Blue Shield. The medical profession has given guidance; established quality standards; imposed cost controls; accepted through their participating doctors terminal responsibility for the financing and provision of services. They have also given us leadership.

5. The subscribing public without whose faith, co-operation, and active participation MHSA would not exist.

We acknowledge on behalf of our membership the unselfish contribution made by all these people. Through their

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interest and support Blue Shield - Blue Cross is being increasingly recognized as an institution for community health services. Mr. Chairman, we must strive not only to preserve, but through government support to encourage this spirit of community effort, personal responsibility, and self-help.

So much for the effort to date. Woth reference to the great number of people who, at the moment, have no protection or are only partially covered - much remains to be done. It has been generally accepted that service type programs provide not only high quality medical care, but a high degree of protection against the expense of illness. We have now turned our energies to the problem of providing medical care to those people who in the past have not been able to obtain this protection for one reason or another. It is incumbent on all of us that it syould be our continued aim to make provision for such a program to each and every family in this area.

We no longer question whether or not this is possible, we are now at the stage where we are find out how.

In this latter regard, in our brief we said that we believe that Government can best lend its influence in extending health care to the citizens of the Atlantic Provinces by giving it sfull co-operation, support and encouragement to the existing voluntary organizations.

We believe that this can best be accomplished

1. Through establishment of principles and standards governing the operations of approved programs;
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3. Through joint effort of Government, the medical profession, and existing agencies to make approved programs more readily and more easily available to those, including our elder citizens, who now have difficulty in obtaining adequate health care coverage.

Risking further repetition, we say that we believe that the adoption of the foregoing is the most practical and economical method of extending adequate health care to the residents of the Atlantic Provinces, while at the same time respecting the rights and privileges of those of our citizens who wish to have a choice of prgram suitable to their needs. It is our belief that the adoption of our recommendations will:

1 Preserve the right of every citizen to accept the responsibility of providing for himself and his family on an individual and voluntary basis;

2. Make adequate health care more readily available to those who, for reasons of health or age, currently have difficulty in obtaining such care or coverage.

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We believe that this is an approach which should merit very careful consideration.

Mr. Chairman, I have spoken on behalf of MHSA and the public we serve. With your permission, I should now like

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to speak as a subscriber -- as a lay member of the community -- as a citizen.

I should like to comment briefly on two points - citizens' rights, and government's responsibilities with respect to the provision of health care and its costs under government sponsorship.

1. Citizens' Rights -- It is my hope that in the decisions reached with respect to the provision of health care, no citizen will be deprived of the right to be responsible for his own well-being and that of his family. I hope that government's interest in his welfare will not extend to the point where his initiative and sense of responsibility are destroyed. As one of the many citizens of this country who has been associated with many medical and lay organizations in the health field, including Red Cross, the Tuberculosis League, and so on, and with plans for prepayment of medical services, I would feel that I am expressing the hope of the citizens of this country that no government would, by force of law, put us and our efforts out of "business." We believe that the voluntary groups such as our own have a great place in the Canadian way of life and we hope that we will never see the day when voluntary agencies are deprived of the privilege of promoting programs in the health field.

2. It seems to me that Government's responsibility

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in prepaid health care programs, quality medical care at a cost which he can afford;

(b) lies in financing the cost of an adequate health care program for those unable to provide it fully for themselves;

(c) lies in correcting the fallacious idea held by some, that government sponsorship means that more services will become available. This can be accomplished only by the provision of more medical and para-medical personnel. Failing an increase in the number of doctors, it is quite likely that under government sponsorship the services of a family doctor would not be as readily available as they are now. Evidence that this is likely to be true is found in the case of England where thousands of people, entitled to so-called free medical care, are joining prepayment organizations comparable to our own in order to obtain the quality of care they want and need - and by so joining, are forced to pay twice for their care, and I can quote statistics to back that up.

(d) lies in not permitting the public to be misled into believing that the quality of medical care will improve under government sponsorship. We are looking forward to more leadership from informed government sources to tell the people that government sponsorship will not in itself result in an improvement in the quality of medical care. Indeed, both citizens and

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government must be realistic enough to anticipate the possibility of some deterioration in the quality of medical care under a government-sponsored program.

(e) lies in the dissipation of the illusion that government-sponsored universal health care is not too costly. In our own province we are now informed that the cost of the Hospital Insurance Plan, which is still in its infancy, already exceeds carefully made estimates by some several millions of dollars. Government announcements of new tax hikes in Manitoba and Saskatchewan for health care purposes are indicative of the high costs involved. The following Canadian Press report on statements made by Premier Frost of Ontario, when he debated the introduction of a government-sponsored medical care plan in the Ontario House, should persuade us of the wisdom of moving slowly -

In a Canadian Press article captioned "Health Plan Price Tag Too High" under date line Toronto March 29 -- We quote: "Premier Frost said today that before getting into any plan of comprehensive prepaid health insurance Canada should take 'a very close look at its price tag.'

"'Canada has already become a high cost economy,' he said. 'And this is affecting our trading and developmental position.'

"The premier said it was 'silly' to believe Ottawa ought to subsidize provincial health plan

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The Federal Government's present commitments are so large, he said, that its participation in hospital insurance 'is unsound.'

"'As a matter of fact, at the present time the Ottawa government states that it simply cannot afford to give us our proper share of tax revenues" If Ontario cannot get its share, what change have we got?

"'I ask the member of this house how in the name of common sense we can turn and ask the Federal Government to subsidize a plan involving medical and drug expenses whenthey cannot afford to pay their bills to the province and even now are running tremendously into debt.'

"Mr. Frost said he wondered how some of the other provinces, 'who are already up to sales taxes of five and six per cent to pay the cost of hospital insurance alone, would ever get the money to pay for what is proposed in these bills.'

"'I do not want the people of this house or the people of our province to be misled by faulty arguments that these plans do not cost money,' he said.

"'We had that same argument in connection with hospital insurance. It is simply not true. The minute government starts to operate one of these plans the costs rise.'

"'In connection with hospital insurance,' he said, 'the cost of hospitals and their administration across Canada is rising very rapidly.'"

End of quote.

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Perhaps we should heed the warning of Graham Hutton, a leading British economist and an assistant to Sir William Beveridge at the time the British Health Plan was begun, when he states in his article, "Beware of the Welfare State," which appears in the October issue of the Reader's Digest -- Quote - "Our welfare state is shockingly expensive. It has a debilitating effect onindividual initiative. It has been extremely unfair to large sections of the population ... And, far from making a dynamic society more dynamic, a top-heavy welfare state could paralyze a mature society." End of quote.

Mr. Chairman, we are sorry to have been so lengthy. However, we hope that this effort will make some small contribution to your thinking on this important question. We appreciate very much the privilege of appearing before you. We extend to your Commission our fullest possible co-operation.

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SUBMISSION OF

MARITIME HOSPITAL SERVICE ASSOCIATION

Appearances:

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Mr. W. R. Fiske	Vice Chairman
Mr. J. A. Comeau	Trustee
Mr. M. A. Farmer, Q.C.	Trustee
Mr. J.A. MacDougall, M.D.	Associate Director in charge of Professional Relations
Mr. W.W.B. Dick, C.A.) Hudson, McMackin and) Company)	Auditors to the Association
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SUMMARY

1. For some years all levels of Government - federal, provincial and local - have shown increasing interest in the health needs of the people of this country.

2. We commend the decision to have a Royal Commission make a searching investigation and study of every facet of the question of the health needs of our people and how best to provide them.

3. The Maritime Hospital Service Association welcomes the opportunity to participate in this most important study. In the following pages we shall attempt to give you the story of the origin of MHSA, its corporate structure, its growth, its accomplishments, its objectives. In this regard:

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Mr. J. A. Comeau	Trustee
Mr. M. [illegible]	[illegible]
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(a) MHSA was originally organized as, and continues to be, a voluntary non-profit prepayment health care program operated as a service to the community.

(b) MHSA commenced operations as a hospital plan, later adding surgical, obstetrical, and medical care. Upon the introduction of Government Hospital Insurance, attention was directed to improving and expanding the medical care program. That resulted in the introduction of comprehensive service type medical contracts and Extended Health Benefits contracts to provide protection against catastrophic medical and paramedical expenses - evidence of the Association's desire and ability to provide the public with the type of coverage it desires and needs.

(c) MHSA has a long history of successful operation. Its record is one of satisfactory growth, sound fiscal policy, maximum member benefits, well stabilized rate structures, and adequate reserves for contingencies and contract improvements.

(d) The MHSA governing board composed of representatives of governments, subscriber nominees, the medical profession, and hospitals is ideally organized to guide the Association in the public's best interest.

(e) Thus MHSA has the ability, capacity, finances, facilities, and staff to administer and underwrite programs of health care for the people of the Atlantic Provinces and is willing and prepared to accept this responsibility.

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Observations and Recommendations.

4. MHSA has an unmatched record of service in the field of health care in the Atlantic Provinces.

5. Continuous membership growth in the existing plans is evidence of subscriber approval of the voluntary approach and satisfaction with present offerings.

6. The most pressing need is coverage for the currently uninsurable and higher risk groups including our elder citizens.

7. We believe that Government can best lend its influence in extending health care to the citizens of the Atlantic Province by giving its full cooperation, support, and encouragement to the existing voluntary organizations. This can best be accomplished -

.... through establishment of principles and standards governing the operations of approved programs;

.... through purchase of coverage for those who are unable to provide for themselves;

.... through joint effort of Government, the medical profession, and existing agencies to make approved programs more readily and more easily available to those, including our elder citizens, who now have difficulty in obtaining adequate health care coverage.

8. It is our belief that the adoption of the foregoing is the most practical and economical method of extending adequate health care to the residents of the Atlantic Provinces.

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(c) ensure the provision of adequate health care for those unable to provide for themselves;

(d) reduce costs to government inasmuch as those who can provide for themselves are given the opportunity to do so - and because reduction in exposure makes the cost more predictable;

(e) permit government to carry out its primary responsibilities to give overall tuidance and control, and to assist those unable to provide adequately for themselves.

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THE MARITIME HOSPITAL SERVICE ASSOCIATION

1. MHSA is a voluntary non-profit prepayment health care corporation. Its organization was prompted by a need for a sound and practical method of spreading the cost of sickness expense among the whole community and a means of prepaying such sickness expense.

2. The public, industry, hospital people, government officials, and the medical profession lent their support. Listed among the charter members of the Board of Trustees were prominent citizens including: federal civil servants; government officials; clergymen; industrialists; lawyers; hospital trustees and administrators; physicians; educationists; miners; merchants.

3. The Trustees were dedicated, as our Board is now, to bringing to the people of these provinces through their own efforts, a prepaid health care program designed to provide the greatest possible protection against sickness expense at the lowest possible cost, and to enrol as widely and as fully as possible in the community, subject only to the need to observe minimum regulations in order to obtain a reasonable spread of risk.

Incorporation

4. MHSA was incorporated in Nova Scotia in 1943; it was re-incorporated in New Brunswick and Prince Edward Island in 1944; and in Newfoundland, in 1949.

Governing Body

5. MHSA is governed by a Board of Trustees

THE MARITIME HOSPITAL SERVICE ASSOCIATION

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2. The public, industry, hospital people, government officials, and the medical profession lent their support. Listed among the charter members of the Board of Trustees were prominent citizens including: federal civil servants; government officials; [illegible]

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Incorporation

4. MHSA was incorporated in Nova Scotia in 1942; it was re-incorporated in New Brunswick and Prince Edward Island in 1944; and in Newfoundland, in 1945.

[illegible]

5. MHSA is governed by a Board of Trustees

composed of twenty-eight members who serve without remuneration.

6. (1) Four ex-officio seats on the Board of Trustees are reserved for representation from each of the four Atlantic Provinces' provincial governments.

(2) Nine trustees represent subscriber members.

(3) Nine trustees represent the medical profession. Bylaws provide for each of the four medical societies in the Atlantic Provinces to be represented on the Board by two nominees with the ninth nominee being elected by the Board.

(4) Six trustees, nominated by the Maritime Hospital Association, represent the 91 public general hospitals in the four Atlantic Provinces.

Sponsoring Bodies

7. The medical care program of MHSA, referred to as "Blue Shield", is sponsored by the Medical Societies of New Brunswick and Prince Edward Island, with sponsorship being extended on an annual basis. The Medical Societies of Nova Scotia and Newfoundland maintain a close liaison with MHSA through the nominees from each Province who occupy seats on the Board.

8. The hospital care program of MHSA, referred to as "Blue Cross" is sponsored by the Maritime Hospital Association.

Affiliations and Membership Standards

9. MHSA maintains membership in important national

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Affiliations and Membership Standards

and international organizations whose primary purposes are (1) to promote non-profit health services, (2) to advance the health and welfare of the public by co-ordinating the methods, coverages, administrative operations and enrolment policies of member organizations.

10. MHSA having met established standards is a voting member of:

(1) Trans-Canada Medical Plans.

This is an organization composed of prepayment non-profit medical care plans which plans are sponsored by the appropriate divisions of the Canadian Medical Association. MHSA is approved officially by the Medical Societies of New Brunswick, Prince Edward Island and Newfoundland to represent the interests of those Provinces on the TCMP Commission. (Exhibit 1)

TCMP membership standards met by MHSA include the following provisions:

(a) Medical sponsorship or approval;

(b) Operation on a non-profit basis;

(c) Free choice of physician;

(d) Service or indemnity type benefits - Where service benefits are provided, a majority of the doctors of the area must be participating physicians who, by agreement, accept the negotiated schedule of fees as full payment under the terms of the contract.

(e) Reasonable promotional activities, avoiding extravagant and misleading statements;

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(e) Reasonable promotional activities, avoiding extravagant and misleading statements

(f) Clearly and simply stated terms of membership and member benefits in Plan literature;

(g) Submission at regular intervals of reports on financial operations and membership growth, reflecting accurately the Plan's operations;

(h) Cooperation with other TCMP Plans in the enrolment and extension of services to employees of firms which operate in more than one Plan area.

(2) National Association of Blue Shield

This is an association with membership open to medically sponsored prepaid medical care plans in the United States and Canada. Its purpose is to promote the establishment and operation of non-profit voluntary medical care plans. It seeks to advance the health and welfare of the community by coordinating the methods, coverages, operations, and enrolment policies of its member plans. It has established approval standards to ensure that a high quality of medical care is maintained and that programs offered meet adequately the health needs of the public (Exhibit 11)

(3) MHSA is also a member of several local, national and international organizations developed for the purpose of advancing, promoting, and coordinating the efforts of hospital-sponsored non-profit hospital service plans. Since the advent of Government-sponsored hospital service, Blue Cross continues to render an important service by supplementing Government hospit

(f) Clearly and simply stated terms of member-

(g) Submission at regular intervals of reports on financial operations and membership growth reflecting accurately the Plan's operations;

(h) Cooperation with other TCMP Plans in the enrolment and extension of services to employees of firms which operate in more than one Plan area.

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(3) MHSA is also a member of several local, national and international organizations developed for the purpose of advancing, promoting, and coordinating the [illegible]

[illegible]

[illegible]

an important service by supplementing [illegible]

programs so that all the facilities and services provided by our community hospitals are available to the public at a low cost through the mechanism of voluntary non-profit prepayment.

MHSA is an accredited member of -

The Maritime Hospital Association
The Canadian Council of Blue Cross Plans
The Blud Cross Association of the American Hospital Association. (Exhibit 111)

11. The foregoing affiliations permit MHSA to participate actively in voluntary non-profit movements sponsored by medical doctors and hospitals throughout Canada and the United States, which today protect over 50,000,000 members for medical services and almost 60,000,000 for hospital services, and which last year paid out over 2½ billions of dollars in membership benefits.

12. These affiliations are also indications of MHSA's desire to utilize every avenue of information, promotion and control in its effort to provide an adequate program of benefits along with efficient and economical service. It is evidence of its willingness to accept self-imposed controls to ensure that standards of quality of service, adequacy of benefits, efficiency and economy of operation are maintained. It also readily exchanges operating experience with other Plans, in order to keep fully informed in this field to the end that the community be extended a service that is second to none by any standard.

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NATURE AND PURPOSE

13. MHSA was first organized in 1943 as a Blue Cross hospital plan offering standard ward care. Until the introduction of Government Hospital Insurance its record was one of expansion and growth. The Blue Shield medical care program was instituted in 1948. Through the active interest and leadership of the medical profession, Blue Shield has grown from a modest indemnity program to one offering a variety of medical and para-medical services, including a contract which provides comprehensive benefits on a service (full payment) basis for practically every service rendered by the attending physician. Through its unique affiliation with the medical profession and hospitals, MHSA has a history of continuous improvement in benefits. It shall continue to study ways and means of making adequate health care more readily available to every citizen including those in the higher risk categories. Its facilities are available for the administration of a program for those unable to provide for themselves and who must have financial help from government or some other agency.

14. MHSA is organized as a non-profit corporation. It is designed and operated to finance health care programs as a community service. It is a voluntary self-help effort employing the principles of insurance to spread the risk amongst those who participate. It is a mechanism through which the cost of all the services - preventive, diagnostic, and curative - essential to good health can be made available to all the people

MHA was first conceived in 1943 as a plan
Cross hospital plan offering [illegible]
until the introduction of [illegible]

Rural medical care program was instituted
through the active interest and cooperation of
medical profession, MHA [illegible]
insurance program to use existing [illegible]

provides comprehensive benefits on a service
payment) basis for practically every [illegible]
the attending physician. [illegible]
tion with the medical profession [illegible]
a history of continuous [illegible]
small centuries to study [illegible]
action case cuts the [illegible]
including those in the [illegible]
activities are available [illegible]
program for those who [illegible]
and the most basic [illegible]
some other agency

4. MHA is sponsored by [illegible]
It is managed and [illegible]
plans as a community service. [illegible]
self-help action [illegible]
to spread the risk amongst those [illegible]
[illegible]

of the Atlantic Provinces in a practical and economical manner. It is also the agency through which the subscriber meets with the representatives of the medical profession and the hospitals for the purpose of working out satisfactory arrangements for the provision of medical and hospital care.

Medical Professions' Cooperation

15. The medical profession has contributed much to the success attained by Blue Shield in the Atlantic Provinces; its sponsorship, cooperation and active participation in the operation of the medical care program has given to the residents of these provinces a program of quality medical care not otherwise possible. For example, the medical profession has given:

(1) Guidance - It has taken a very active interest in Blue Shield and cooperated wholeheartedly in the drafting of the various medical care and hospital care programs thus assuring the public that benefits to be provided are consistent with medical need, good medical practice, and the availability of good medical care. Continuous review of existing programs ensures that Blue Shield program benefits keep pace with the great advances made in the field of medicine.

(2) Lower Costs - In its negotiations with medical societies on the schedules of fees to be used in payment for services rendered Blue Shield members, MHSA recognizes that the profession is often prepared to accept less than its usual charges. This results in a tangible saving to

of the Atlantic Provinces in a practical and cooperative [illegible]. It is also the agency through which the [illegible] another meets with the representatives of the medical profession and the hospitals for the purpose of working out satisfactory arrangements for the provision of medical and hospital care.

Medical Professional Cooperation

15. The medical profession has contributed [illegible] to the success attained by Blue Shield in the Atlantic Provinces; its sponsorship, cooperation and active participation in the operation of the medical care program has given to the residents of these provinces a program of quality medical care not otherwise [illegible]. For example, the medical profession has [illegible]

(1) Guidance - It has taken a [illegible] in Blue Shield and cooperated [illegible] the drafting of the various medical [illegible]

that benefits to be provided are clinically [illegible] medical need, good medical practice, and the availability of good medical care. Continuous review of existing programs ensures that Blue Shield program does its best keep pace with the [illegible] advances made in the field of medicine.

(2) Lower Costs - In its negotiations with medical societies on the schedules of fees to be [illegible] members, MSSA recognizes that the professions often prepared to accept less than the usual [illegible]

Blue Shield subscribers.

(3) Cost Controls - The provincial medical societies have appointed reference committees composed of outstanding and experienced doctors. To these committees are referred such questions as - payments for services not listed in the formal schedules of fees; questions regarding extent of services rendered and charges therefor, thus providing the receiver and the provider of services the right of recourse in case of dispute. The intelligent, fair, and unbiased decisions reached are accepted by all parties.

(4) Quality - The medical profession has manifested a keen interest in maintaining a high standard of medical care. For example, the societies have taken the position that payments for x-ray services be made only to qualified radiologists; that payments for psychiatric care be made only to specialists in psychiatry - such self-imposed standards assure the public that a high quality of medical care is provided.

(5) Financial Responsibility - The participating physicians' agreement signed between MHSA and each participating physician provides for the prorating of claim payments in the event that expenses exceed income. (A similar "prorating clause" is found in the participating hospital agreement.) Thus the medical profession (and the hospitals) accept the ultimate responsibility for the financing and the provision of subscriber

[illegible] Shield subscribers.

(4) Cost Controls - The provincial [illegible] societies have appointed reference committees composed of understanding and experienced [illegible]. To these committees are referred each question [illegible] - payments for services not [illegible], schedules of fees; questions regarding [illegible] services rendered and charges thereof, [illegible] providing the receiver and the provider services the right of recourse in case [illegible]. The intelligent, fair, and [illegible] decisions reached are accepted by all parties.

(4) Quality - The medical profession has [illegible] a keen interest in maintaining a high standard of medical care. [illegible] the societies have taken the position that payments [illegible] services be made only [illegible] that payments [illegible] to specialists in preference [illegible] increased standards ensure the public [illegible] quality of medical care [illegible].

(5) Financial Responsibility - The [illegible] physicians' agreement signed between [illegible] each participating hospitalization [illegible] providing [illegible] claim payments [illegible] average [illegible] income [illegible] clause" [illegible] agreement). Thus the [illegible]

benefits.(Exhibit XI)

Non-Profit Feature

16. The non-profit feature of MHSA liest in the fact that there are no stockholders drawing profits, that members of the Board of Trustees receive no reimbursement for their services as Board members, that no sponsor or affiliated organization or employee of MHSA receives any commission or bonus payments. After the cost of administration has been provided for, the balance of the subscriber's membership dollar is available for the payment of benefits, for the provision of stabilization of membership rates, for contingency reserve, and for subscriber benefit improvements. This arrangement permits the us of the membership dollar for the greatest possible benefits.

Choice of Programs

17. In order to meet the needs and wishes of ever segment of the population, MHSA offers the following standard contracts:

(1) Blue Shield Comprehensive Surgical-Obstetrical-Diagnostic and Medical Care on a "service" basis. (Exhibit IV)

(2) Blue Shield Surgical-Obstetrical and In-Hospital Medical Care on a "service" basis. (Exhibit V)

(3) Blue Shield Surgical-Obstetrical and In-Hospital Medical Care on an "indemnity" basis. (Exhibit

(4) Blue Cross Supplementary Hospital benefits for semi-private and private room service basis. (Exhibit VII)

benefits. (Exhibit XI)

16. The non-profit feature of MHSA lies in the fact that there are no stockholders [illegible] that members of the Board of Trustees [illegible] reimbursement for their services as Board members, that no sponsor or affiliated organization [illegible] employee of MHSA receives any compensation or payments. After the cost of administration [illegible] provided for, the balance of the premium [illegible] only dollar is available for payment [illegible] for the provision of stabilization of membership rates, for contingency reserves, and for [illegible] benefit improvements. This arrangement [illegible] of the membership dollar [illegible]

Choice of programs

17. In order to meet the needs and wishes of [illegible] segment of the population, MHSA offers the following [illegible]

Diagnostic and Medical care on a "service" basis. (Exhibit IV)

Medical care on a "service" basis. (Exhibit [illegible])

Blue Cross supplementary hospital benefits [illegible] semi-private and private room service [illegible]

(5) Extended Health Benefits for hospital, surgical, obstetrical, diagnostic, medical, and para-medical care. (Exhibit VIII)

18. Through these contracts subscribers are offered a broad range of preventive, diagnostic, and curative services - an adequate program geared to provide a wide range of health services to meet the needs and wishes of the public. The subscriber is given complete freedom of choice in the selection of his medical doctor or hospital. In fact, MHSA makes payment for services rendered by non-participating physicians and hospitals in the same amount as would have been paid for a similar service provided by a participating doctor or hospital.

Membership Standards - Enrolment

19. Membership is available to most residents of the Atlantic Provinces. Persons who work where there are five or more persons on the payroll may apply for membership through a group at their place of employment. Over 2200 firms provide the facilities of monthly deductions of membership fees. Many employers encourage their employees to enrol by making a contribution towards membership costs. There are no age limits or health requirements for those who apply for group membership when first eligible. To qualify, groups must meet minimum percentage requirements.

20. Those persons who are unemployed, self-employed, or employed where there are fewer than ten on the payroll may apply for non-group membership. The exception to complete availability of membership

[illegible] with benefits for hospital, surgical, obstetrical, diagnostic, medical, and preventive medical care. (Article VIII)

[illegible] these services [illegible] are [illegible]

provide a wide range of health services [illegible] needs and wishes of the public. The [illegible] is given complete freedom of choice [illegible] his medical doctor or hospital. [illegible] payment for services rendered by [illegible] physicians and hospitals to the [illegible] have been paid for a similar service [illegible] participating doctor [illegible]

Membership [illegible]

19. Membership is [illegible] the Atlantic [illegible] are five or more persons [illegible] for membership through [illegible] employment. Over 20 [illegible]

encourage their [illegible] public towards [illegible] limits or [illegible] group membership [illegible]

[illegible]

[illegible] the payroll may apply for [illegible]

is that non-group applicants must be under 60 years of age at the time of joining and are required to complete a medical questionnaire. In this latter regard, fewer than 2 per cent of those applying are refused membership for medical reasons.

21. It should be noted that there are no age limits for enrolled subscribers. Important, too, to the subscriber is his right to continue as a direct-pay subsecriber when he no longer may be eligible for group membership, the right to add newborn children to family contracts, the right of dependent childern who are no longer eligible for dependents' benefits under family contracts to be automatically extended the right to individual membership, and the right of a newly married subscribed to add the new wife or husband to the contract. Once enrolled, a subscriber may continue his membership regardless of age or state of health.

22. Plan membership has grown at a satisfactory pace - over 200,000 MHSA members have surgical-obstetrical-medical coverage; over 271,000 hold supplementary hospital contracts for semi-private room service. Exhibit LX shows that the majority of our members enjoy "service" type benefits.

Fulfilling Purpose

23. While the process of program improvement never ends, it seems fair to state that under existing arrangements the subscribers' interests are well served, and that through the splendid cooperation given by the medical profession and participating hospitals, MHSA is

[illegible]

[illegible]

complete a medical questionnaire. [illegible] regard, fewer than 2 per cent of [illegible]

21. It should be noted that there are no [illegible] for enrolled subscribers. Important, too, [illegible] subscriber is his right to continue as a [illegible] subscriber when he no longer may be eligible [illegible] group membership, the right to add newborns [illegible] to family contracts, the right of terminated [illegible] who are no longer eligible for dependent [illegible] under family contracts to be automatically [illegible] the right to individual membership, and [illegible] newly married subscribers [illegible] ban) to the contrary. [illegible] continue his membership regardless of age [illegible] of health.

22. Plan membership. [illegible] page - over 200,000 Blue [illegible] contractual-medical [illegible] supplementary hospital contracts [illegible] service. Exhibit IX shows that the majority of [illegible] here enjoy "service" type benefits.

23. While the [illegible] never ends, it seems fair to state that under [illegible] arrangements the subscribers' interests are well [illegible] and that through the spirit of cooperation given by [illegible]

fulfilling its purpose in making adequate programs of health care available on a voluntary low-cost basis.

RECORD OF OPERATION

Finance

24. The record of operations of MHSA is one of sound fiscal policy, maximum member benefits, well stabilized rate structure, and adequate reservices for contingencies and contract improvements.

25. For the period from June 1, 1943, the date of inception, through December 31, 1960, the financial record of MHSA respecting subscriber income and expenses is as follows:

Subscriber revenue	$65,982,902.87	100.0%
Benefits	$57,013,888.82	86.4%
Operating expense	$ 6,744,090.56	10.2%
Available for future benefits	$ 2,224,923.49	3.4%

26. As shown in the balance sheet (Exhibit X) the total reserve for future benefits as of December 31, 1960 is $2,880,238.38. This consists of the balance of subscriber revenue available for future benefits as above, plus investment income in the amount of $655,314.89. We are confident that MHSA has an unparallelled record of community service in the Atlantic Provinces. The cost of administration has been modest. Its reserves assure the membership that their contract rights are adequately protected.

Benefit Description

27. In addition to the basic contracts already

fulfilling its purpose in making adequate programs of health care available on a voluntary [illegible] basis.

"HOW DO PROGRAMS

24. The record of operations of MHSA in [illegible] stabilized rate structure, and adequate reserve [illegible]

25. For the period from June 1, [illegible] of MHSA respecting subscriber income and expenses [illegible] as follows:

Subscriber revenue	$[illegible]
Benefits	$[illegible]
Operating expense	$[illegible]
Available for Income	

26. As shown in the balance sheet [illegible] the total reserve for future benefits as of December [illegible] 1960 is $2,880,[illegible]. This compares [illegible] subscriber revenue available [illegible] above, plus investment income [illegible] $[illegible]. We are confident that MHSA has [illegible] earmarked reserve [illegible] provinces. The [illegible] administration has [illegible] The reserves assure the membership that their [illegible]

mentioned, MHSA underwrites special contracts tailored to meet the specifications of individual groups. However, for the purpose of this submission, we shall review only the five basic contracts under which the majority of MHSA membership is covered.

(1) Blue Shield Plan #3 - This is a "service benefit" comprehensive surgical-obstetrical-medical contract under which practically every service provided by a general physician in the hospital, patient's home, or doctor's office is available. In addition, is provided the services of a specialist consultant when requested by the attending doctor, as well as diagnostic aids such as E.C.G.; B.M.R.; x-ray and laboratory services provided by the attending doctor.

The "service benefit" provision is an agreement under which, for specified services, participating physicians accept MHSA payments as full payment, as contrasted with an "indemnity" provision, under which the subscriber is responsible for any difference between the indemnity schedule of fees and the doctor's charge. (Exhibit IV)

(2) Blue Shield Plan #2 - This is also a "service benefit" contract with all the features of Plan #3 except that medical care for purely medical cases is limited to in-hospital treatment and there is no provision for diagnostic x-ray and laboratory services. (Exhibit V)

to meet the specifications of individual groups. However, for the purpose of this summary, we shall review only the five basic contracts under which the majority of MHBA membership is covered.

(1) Blue Shield Plan #5 - This is a "service [illegible] every service provided by a general [illegible] in the hospital, patient's home, or [illegible] office is available. In addition, [illegible] provided the services of a specialist [illegible] assistant when requested by the attending doctor, as well as diagnostic aids such as E.C.G.; B.M.R.; x-ray and laboratory services provided by the attending doctor.

The "service benefit" provision [illegible] agreement under which, for specified services [illegible] as full payment, as contrasted with a "indemnity" provision, under which the subscriber is responsible for any difference between the indemnity schedule or less than the doctor's charge. (Exhibit IV)

(2) Blue Shield Plan #2 - This is also a "service benefit" contract with all the features of Plan #3 except that medical care for purely medical cases is limited to in-hospital treatment and there is no provision for diagnostic x-ray and laboratory services. (Exhibit V)

(3) Blue Shield Plan #1 - This is an "indemnity" contract providing surgical-obstetrical and in-hospital medical benefits. The "indemnity" payments are according to the MHSA $300 indemnity schedule of fees. (Exhibit VI)

(4) Blue Cross Hospital Plan - This is a contract which covers the hospital's extra charge for semi-private or private room accommodation, over the government's payment for standard ward service, and in addition provides benefits for specified out-patient services not included in the government hospital insurance program. (Exhibit VII)

(5) Extended Health Benefits - This type of coverage is often referred to as "Major Medical" insurance, and provides for payment by the subscriber of a deductible sum, similar to the deductible in an automobile insurance contract, and a co-insurance payment, generally of 20 per cent or 25 per cent of the balance of the expenses. We refer to our contract as "Extended Health Benefits since it describes more accurately the protection provided. This contract provides payments for additional hospital and medical expenses, and para-medical services such as: private duty nursing care in or out of hospital; prescription drugs; ambulance; prosthetic appliances; rental of iron lung; etc. This contract is sold as a supplement to a MHSA

(3) Blue Shield Plan #1 - This is an "indemnity" [illegible]

payments are according to the MMMA $300 indemnity schedule of fees. (Exhibit III)

(4) Blue Cross Hospital Plan - This is a contract which covers the hospital's extra charge for [illegible]

over the Government's payment for ward service, and in addition provides benefits for specified out-patient services not included in the Government hospital [illegible]

(5) Extended Health Benefits - This type of [illegible] age is often referred to as "Major Medical" insurance, and provides for payment by the subscriber of a deductible sum, in the deductible in an automobile insurance contract, and a co-insurance payment, usually of 20 per cent or 25 per cent of the balance of the expenses. We refer to [illegible] contract as "Extended Health Benefits" [illegible] provided. This contract provides payments for additional hospital and medical expenses, and para-medical services such as: private duty nursing care in or out of hospital; [illegible] appliances; rental of iron lung, etc. This contract is sold as a supplement to a Major

standard contract.

Rates vary among groups due to variations in such factors as basic contract benefits, the amount of deductible and co-insurance applicable and the group's distribution according to age, marital status, sex,and income. Benefits for each person protected are determined by each group and can be as much as $25,000 per person. (Exhibit VIII)

28. We wish to point out that our Extended Health Benefits contract is a supplement to our basic contracts whichprovide a broad base of surgical-obstetrical-diagnostic-medical care on a first dollar basis. While we offer a deductible-coinsurance supplement, we recognize that such coverage is not universally acceptable. It is useful for specific groups to which the principle of deductible payment and a percentage coinsurance is attractive. By contrast, however, the recently adopted Federal Civil Service contract with a deductible-coinsurance provision created considerable dissatisfaction on the part of many federal employees who felt obliged to discontinue their then-existing more comprehensive coverage in order to receive a Government contribution towards the cost of their health care.

Facilities - Staff

29. The majority of MHSA experienced well-trained staff, which numbers 125 persons, of which one-third have at least 10 years of employment and one-half have at least 5 years, work in the MHSA

Rates vary among groups due to variations in such factors as basic contract benefits, the amount of deductible and co-insurance applicable and the group's distribution according to age, marital status, sex, and income. Benefits for each person protected are determined by each group and can be as much as $25,000 per person. (Exhibit VIII)

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federal employees who felt obliged to discontinue their then-existing more comprehensive coverage in order to receive a Government contribution towards the cost of their health care

Facilities - Staff

29. The majority of MHSA experienced well-

one-third have at least 10 years of employment and

modern, well-equipped head office building located at 110 MacBeath Avenue, Moncton, N. B.. This is MHSA's own property. Branch offices are maintained at Charlottetown, Fredericton, Halifax, Saint John, and St. John's, Newfoundland.

CURRENT NEEDS

30. While it is true that MHSA operations are highly efficient and MHSA has progressed at a satisfactory pace, it is equally true that there are still community health needs to be met.

31. The most pressing needs are those related to the extension of membership to the people of the Atlantic Provinces who now lack adequate protection. We are confident that out of current studies will evolve methods of underwriting coverage for those persons who presently have difficulty in obtaining, or in financing membership in a voluntary health care program.

32. The segments of the population most in need of protection and our thoughts for underwriting a program of benefits for these groups are as follows:

(1) Indigents

There will always be those who are unable to provide for themselves - these we shall always have with us; consequently to some extent we are our brother's keeper. Considerable study has been given to the problem of financing health care for the indigent. It appears that Government must assume a responsible role in the solution of the problem. MHSA is prepared to extend

[illegible]

[illegible]

own property. Branch offices are maintained at [illegible]

[illegible]

CURRENT NEEDS

30. While it is true that MHSA operations are highly efficient and MHSA has progressed at a satisfactory pace, it is equally true that there are still community health needs to be met.

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There will always be those who are unable to provide for themselves - those we shall always have with us; correspondingly to some extent we are our brother's keeper. Considerable study has been given to the problem of financing health care for the indigent. It appears that Government must assume a responsible role in the solution of the problem. MHSA is prepared to [illegible]

every possible assistance.

We suggest that a practical solution might be for Government to enrol as members of MHSA those indigents who are receiving public assistance. An arrangement under which all indigents receiving formal public assistance (what constitutes formal public assistance must, of course, have to be carefully defined) could be enrolled in MHSA would ensure efficient operation and freedom from political influence on a basis protecting the individual's dignity at the time of admission to the hospital or rendering of care by the doctor. We are willing to administer their membership at cost.

(2) High Risk Groups

Another problem is the extending of coverage to those who for reasons of health of age are classified as higher risk groups, some of whom are currently considered ineligible for membership. With respect to the aged it should not be assumed that all persons over age 65 are without mecical coverage. We wish to point out that one of the basic principles of MHSA has always been that membership rights and contract benefits may be continued for all enrolled members regardless of age, condition of health, or benefits received. We have many members who are over age 65 and who continue to enjoy the same contract benefits as are provided other members. Evidence of this fact was developed in a recent

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An arrangement under which all indigents receiv-
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tract benefits as are provided other members.
Evidence of this fact was developed in a recent

study of a block of MHSA claims totalling nearly half-a-million dollars. Of these claims, 9.1 per cent were for persons age 65 or over, but more significant, the cost of the claims for these older age persons was 14.9 per cent of the total. The problem of providing hospital-medical coverage for elder citizens obviously lies in the fact that the volume and the cost of services increase with increasing age, and further, that the reduced income status of the older age group makes it difficult for many to meet the cost of hospital-medical coverage.

As with the problem of health care for those who cannot provide for themselves, considerable study has been made in this regard, and the concern of the medical profession with regard to care for the indigent and elder citizens and its willingness to share in the solution is indicated in the following Resolution adopted at the recent annual meeting of the Medical Society of New Brunswick.

"BE IT RESOLVED:

"THAT the Economics Committee be requested to continue its study on 'Indicare' and 'Eldercare'. THAT the N.B. Medical Society, direct the Economics Committee and the Sponsored Plan to study and develop methods of instituting a Plan whereby the indigent groups and elderly persons of this province may have available to them Prepaid Medical Care, in keeping with the Statement of

study of a block of MMSA claims totalling nearly

9.1 per cent were for persons age 65 or over, but more significant, the cost of the claims for these older age persons was [illegible]

medical coverage for older citizens obviously lies in the fact that the volume and [illegible] services increase with increasing age. [illegible] further, that the reduced income [illegible] the older age group makes it difficult for them to meet the cost of hospital-medical coverage.

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"BE IT RESOLVED:

"THAT the Economics Committee be [illegible] to continue its study on 'Indigent and [illegible]';

"THAT the [illegible] Medical Society, through the Economics Committee and the [illegible] study and develop methods of [illegible] whereby the indigent groups and [illegible] of this province may have available to them [illegible]

Policy of the C. M. A.

"THAT should the welfare authorities be in agreement and will consider the payment of the premium necessary, this Society is willing to make a definite contribution in order to get a Plan into effect under which Prepaid Medical Care may be made available for Indigent Persons and needy Elderly citizens."

33. We should welcome the adoption of standards governing benefit offerings, regulations, and underwriting practices which would enable MHSA to extend coverage to those who currently have difficulty in qualifying for membership under present regulations. Thus an adequate health care program could be made available to every resident regardless of state of health or age.

OBSERVATIONS AND RECOMMENDATIONS

34. There is a growing concern to make adequate health care available to all who need it. In this regard much is said about "our rights" - little about our duties and responsibilities. We ought not to forget that in a democratic society like ours there is another kind of "right" - the right to be always primarily responsible for our own keep and that of our families. In our social planning we ought to aim to help the individual, but never to destroy his initiative or his sense of responsibility. It has been said that a democratic government best serves its people when it does for them only those things which they cannot do for themselves. With respect to the needy, it is

Policy of the C. M. A.

"THAT should the welfare authorities be in agreement and will consider the payment of the premium necessary, this Society is willing to make a definite contribution in order to get a plan into effect under which hospital benefits could be made available for indigent persons and for Elderly citizens."

33. We should welcome the adoption of [illegible] writing practices which would enable MHSA to [illegible] coverage to those who currently have difficulty qualifying for membership under present regulations. Thus an adequate [illegible] health or age.

CONSERVING AND IMPROVING HEALTH

34. There is a growing [illegible] health care available to all who need it. In this regard much is said about "our rights" - [illegible] duties and responsibilities. We [illegible] that in a democratic society [illegible] there is [illegible] kind of "right" - the right to be always provided [illegible]

In our social planning we ought to aim to help the individual, but never to teach him a [illegible] does for them only those things which they cannot do for themselves.

recognized that there are, and always will be, people of all ages who cannot provide for themselves. However, we do not think that it is wise or necessary to implement a compulsory program to meet this problem.

35. Rather we feel that in the promotion of existing voluntary organizations there are real advantages to be gained, such as public approval and voluntary participation; savings to Government; medical guidance, flexibility of policies to meet local needs and to permit changes to conform with changes in the healing arts; elimination of duplication of administractive facilities and staffs; efficiency and economy of operation unhampered by political influences or pressures.

36. Thus, we believe that Government can best lend its influence in extending health care to the citizens of the Atlantic Provinces by giving its full cooperation, support, and encouragement to the existing voluntary organizations.

37. We believe that MHSA possesses the qualities essential to the successful operation of such a health program not only for those who have and do voluntarily participate, but also for those who are the direct concern of Government. It has been shown that:

(1) The Association is a coordinating agency on whose Board of Trustees sit representatives of Government, the medical profession, the hospitals, and the subscribers. This is democratic self-help in action.

(2) Its non-profit feature permits maximum benefits

recognized that there are, and always will be, people of all ages who cannot provide for themselves. However, we do not think that it is wise or necessary to implement a compulsory program to meet this problem.

35. Rather we feel that in the promotion of existing voluntary organizations there are [illegible] advantages to be gained, such as public approval and voluntary participation, advice to [illegible] guidance, flexibility of policies [illegible] and to permit changes to cope with changes [illegible] healing arts; elimination of duplication of [illegible] tractive facilities and effort; [illegible] economy of operation unencumbered by [illegible] influences or pressures.

36. Last, we believe that [illegible] and its influence in extending health [illegible] citizens of the Atlantic Provinces by promoting cooperation, support, and encouragement [illegible]

37. We believe that [illegible] essential to the successful operation [illegible] program not only for those who have [illegible] participate, but also for those who are the [illegible] concern of Government. It has been shown that

(1) The Association is a coordinating agency [illegible] whose Board of Trustees [illegible] Government, the medical profession, the [illegible] help in action.

and lowest costs.

(3) Its administration is conservative, sound, and efficiently managed.

(4) Contract benefits keep pace with medical progress and have medical society approval. Evidence of public approval is its enrolment progress which is outstanding in this area. Its present contracts provide various levels of coverage to meet the various needs and desires of the subscribing public; its aim as to coverage for the indigent and marginal risk groups is to provide adequate care for every resident who needs it. We hope that the work of the Commission will so focus attention on this problem as to make possible the early accomplishment of this objective.

(5) It has gained the support and cooperation of the medical profession, the hospital, and business and labor leaders, which have contributed to its success as a service to the community.

38. Thus MHSA has the staff, facilities, finances, ability and capacity to administer and underwrite programs of health care for the community and is willing and prepared to accept this responsibility.

39. In conclusion, we respectfully submit that Government can best serve the public in its quest for an adequte health care program through its cooperation with the existing voluntary prepayment health care programs, and through the purchase by Government of approved coverage for the indigent.

40. We hope that out of present studies will

and lower [illegible]

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(5) It has caused the [illegible] medical profession, [illegible] labor leaders, [illegible] [illegible] as a service [illegible]

32. This [illegible] [illegible] ability and consent to [illegible] programs of health [illegible] willing and prepared to accept [illegible]

33. In conclusion, we respectfully submit [illegible] government can best serve the public [illegible] an adequate health care program through [illegible] with the extension and [illegible] programs, and through the purchase [illegible] approved coverage for the indigent.

34. We hope that out of [illegible]

evolve a practical method extending an adequate program of health care to the higher risk group including the elder citizen at a cost within his means. This can best be accomplished by the joing efforts of Government, the medical profession, and MHSA.

41. In the establishment of an approved program we submit that the following principles should be recognized.

(1) There should be standards governing benefits and operations.

(2) Membership should be voluntary and available to every resident regardless of age or state of health.

(3) There should be free choice of physician.

42. The Executive Committee of the Board of Trustees of MHSA at its meeting held September 30, 1961, stated that -

"KEEPING IN MIND the foregoing recommendations;

"KEEPING IN MIND that the number of residents of the Atlantic Provinces who have chosen the voluntary approach to financing medical care through membership in MHSA, Maritime Medical Care, the insurance companies, cooperative societies and self-insured groups is indeed significant;

"KEEPING IN MIND that this success has thrown the spotlight of politcal interest upon such elements as the aged and the indigent who are not able to participate in a voluntary program

evolve a practical method extending an adequate program [illegible]

be accomplished by the joint efforts of Government, the medical profession, and MHSA.

41. In the establishment of an approved program we submit that the following principles should be recognized.

(1) There should be standards governing [illegible] and operations.

(2) Membership should be voluntary and available to every resident regardless of age or state of health.

(3) There should be free choice of physicians.

42. The Executive Committee of the Board [illegible] Trustees of MHSA at its meeting held September [illegible] 1961, stated that -

"KEEPING IN MIND the corresponding [illegible] decisions;

"KEEPING IN MIND that the number of residents of the Atlantic Provinces who have chosen [illegible] voluntary approach to financing medical care through membership in MHSA, Maritime medical societies and self-insured groups is indeed significant;

"KEEPING IN MIND that this success has [illegible] the spotlight of politics interest upon [illegible] elements as the aged and the indigent who are [illegible]

on the same terms as their more fortunate neighbors;

"KEEPING IN MIND that voluntary prepayment programs have succeeded so well that they have given rise to a growing popular conviction that somehow this protection must be extended to everyone;

"KEEPING IN MIND that the members of voluntary medically-sponsored non-profit plans are happy and satisfied with the high quality comprehensive care provided;

"BE IT THEREFORE RESOLVED:

"THAT this Board reaffirm its belief that adequate care for the self-supporting can best be extended through voluntary means;

"THAT MHSA shall be glad to meet with governments and medical societies of the Atlantic Provinces for the purpose of finding a means whereby the indigents and the elder citizens of these provinces may be extended a program of health care as may be deemed adequate by this Commission, the promotion of which shall be in the best interests of all concerned."

EXHIBIT IV

CONTRACT DESCRIPTION

BLUE SHIELD - Comprehensive Sectice Plan #3

SURGICAL, OBSTETRICAL AND MEDICAL CARE ....

IN THE HOSPITAL,DOCTOR"S OFFICE OR PATIENT"S HOME ...

PAYS PARTICIPATING PHYSICIANS ... "SERVICE BASIS...

The following contract benefits are provided on a "service basis when rendered by a participating physician:

- Surgical procedures
- Services of assisting surgeon
- Mternity
- Services of anaesthetist
- Consultant services
- Treatment of fractures and dislocations
- Endoscopic procedures
- Medical care in home or doctor's office
- Diagnostic x-ray
- Laboratory services.

In the event services are rendered by a non-participating doctor, MHSA will pay an amount equal to that which would have been paid to a participating doctor for the same services.

MONTHLY GROUP MEMBERSHIP RATES

Single ...	$3.24	Married ...	$9.00
			$8.40 (Nfld)

Note: Special package program rates are available when this program is sold in conjunction with the Blue Cross supplementary hospital service contract.

For descriptive folder see Exhibit IV(a)
For specimen contract see Exhibit IV(b)

CONT

BLUE SHIELD - Oc

SURGICAL, OBSTETRICAL AND MEDICAL CARE ....

B. [illegible]

[illegible] PARTICIPATING [illegible]

The following contract benefits are provided [illegible] "service basis when rendered by a participating physician:

[illegible]

Services of assisting surgeon

[illegible]

Services of anesthetist

[illegible]

Treatment of fractures and dislocations

Endoscopic procedures

Medical care in home or office [illegible]

[illegible]

Laboratory services.

To the extent services are rendered by a non-participating doctor, MHS will pay an amount equal to that which would have been paid to a participating doctor for the same services.

[illegible]

Single ... $4.24 Married ... $[illegible].00

Note: Special maternity program rates are available when this program is sold in conjunction with the Blue Cross hospital "service contract".

For amendment contract see [illegible]

EXHIBIT V

CONTRACT DESCRIPTION

BLUE SHEILD - Service In-Hospital Plan #2

SURGICAL,OBSTETRICAL,AND IN-HOSPITAL MEDICAL CARE . . .
PAYS PARTICIPATING PHYSICIANS . . . "SERVICE BASIS...

The following contract benefits are provided on a "service"basis when rendered by a participating physician:

Surgican procedures
Services of assistant surgeon
Maternity
Services of anaesthetist
Consultant services
Treatment of fractures and dislocations
Endoscopic procedures
Medical care in hospital

In the event services are rendered by a non-participating doctor, MHSA will pay an amount equal to that which would have been paid to a participating doctor for the same services.

MONTHLY MEMBERSHIP RATES

	Single	Married
Group	$1.60	$4.25
	(Nfld)	$3.65
Non-Group	$2.00	$5.00

For descriptive folder see Exhibit V(a)
For specimen contract see Exhibit V(b)

BLUE SHIELD - Service In-Hospital Plan #2

PAYS PARTICIPATING PHYSICIANS . . . "SERVICE BASIS"

The following contract benefits are provided on a "service"basis when rendered by a participating physician:

Maternity

Services of anesthetist

Consultant services

Treatment of fractures and dislocations

Endoscopic procedures

Medical care in hospital

In the event services are rendered by a non-participating doctor, MHSA will pay an amount equal to that which would have been paid to a participating doctor for the same services.

	Single	Married
Group	$1.60	$4.25

" For descriptive folder see Exhibit V(a)
For specimen contract see Exhibit V(b)

EXHIBIT VI

CONTRACT DESCRIPTION

BLUE SHEILD - Indemnity Plan #1

SURGICAL,OBSTETRICAL,AND IN-HOSPITAL MEDICAL . . .

The following contract benefits are provided and payments are made according to the MHSA $200 indemnity schedule of fees:

Surgical procedures

Services of assistant surgeon

Maternity benefits

Services of anaesthetist

Consultant services

Treatment of fractures and dislocations

Endoscopic procedures

Medical care in hospital

MONTHLY MEMBERSHIP RATES

	Single	Married
Group	$1.40	$3.60
	(Nfld)	$3.00
Non-Group	$1.75	$4.25
	(Nfld)	$3.60

For descriptive folder see Exhibit VI(a)
For specimen contract see Exhibit VI(b)

EXHIBIT VI

CONTRACT DESCRIPTION

BLUE SHIELD - Indemnity Plan #2

SURGICAL, OBSTETRICAL, AND IN-HOSPITAL MEDICAL . . .

The following contract benefits are provided and payments are made according to the MHSA $200 indemnity schedule of fees:

Services of assistant surgeon

Services of anesthetist

Consultant services

Treatment of fractures and dislocations

Endoscopic procedures

Medical care in hospital

	Single	Married
Group	$1.40	$3.60
	(Mrid) $3.00	
	(Mrid) $2.60	

For descriptive folder see Exhibit VI(a)
For specimen contract see Exhibit VI(b)

EXHIBIT VII

CONTRACT DESCRIPTION

BLUE CROSS - Supplementary Hospital Service

The following contract benefits are provided as supplementary services to the Government Hospital Insurance Programs:

Semi-Private of Private Room Accommodation: MHSA pays the difference between the hospital's daily charges for semi-private and ward accommodations; in private room accommodations, such difference or $4 per day, whichever is the greater.

Ancillary Hospital Services - outside the Atlantic Provinces. MHSA will pay an allowance of up to $150 per admission for additional ancillary services not covered by a Government Hospital Insurance program.

Emergency Out-Patient Hospital Services - Within 48 hours of an accident if not available under the Government Hospital Insurance program.

Elective Surgery, Out-Patient Services - Out-patient hospital service for elective surgery up to $10, if not available under the Government Hospital Insurance plan.

MONTHLY MEMBERSHIP RATES

	Single	Married
Group	$ .75	$1.85
Non-Group	$1.25	$2.50

Special package program rates are available when this program is sold in conjunction with Blue Shield Plan #3 - comprehensive service contract.

For specimen contract see Exhibit VII(a)

EXHIBIT VII

BLUE CROSS - Supplementary Hospital Service

The following contract benefits are provided as supplementary services to the Government Hospital Insurance Program:

Semi-Private or Private Room Accommodation: MHSA pays the difference between the hospital's daily charges for semi-private and ward accommodations; in private room accommodations, such difference or $4 per day, whichever is the greater.

Ancillary Medical Services - [illegible] provinces. MHSA will pay an allowance of up to $150 per admission for additional ancillary services not covered by a [illegible]

Emergency Out-Patient Hospital Services - Within 48 hours of an accident if not available under the Government Hospital Insurance program.

Elective Surgery, Out-Patient Services - Out-patient hospital service for elective surgery up to $10, if not available under the [illegible]

MONTHLY MEMBERSHIP RATES

	Single	Married
Group	$ .75	$1.85
Non-Group	$1.25	$2.50

[illegible] program is sold in conjunction with Blue Shield Plan #3 [illegible]

For specimen contract see Exhibit VIII(a)

CONTRACT DESCRIPTION

EXTENDED HEALTH BENEFITS

Extended Health Plan benefits provide that if, in any calendar year, while coverage is in force, illness expenses incurred by a participant exceed the total allowances under the basic hospital, surgical, medical contracts, and the deductible sum in the contract (generally $100 per participant), MHSA pays 75 per cent (or (80%) of such excess charges for the provision of the following benefits:

Fees of currently registered graduate nurses.

Services of a qualified physiotherapist.

Charges for drugs and medicines which can be obtained only on a licensed physician's prescription.

Customary charges of physicians when services are rendered outside the Atlantic Provinces.

Hospital charges for private room accommodation.

Artificial appliances, crutches, splints, casts, trusses, braces.

Oxygen and rental of equipment for its administration.

Rental of wheel chair, iron lung, hospital type bed.

Charges for professional ambulance service.

Group membership rates are variable and are dependent upon such factors as the level of basic benefits, the amount of the deductible and co-insurance applicable, and the group's distribution according to age, marital status, sex, and income.

For descriptive folder see Exhibit VIII(a)
For speciman contract see Exhibit VIII(b)

EXHIBIT VIII(b)

MARITIME HOSPITAL SERVICE ASSOCIATION

A NON-PROFIT CORPORATION
(Hereinafter referred to as the Service Corporation)

GROUP CONTRACT
for
EXTENDED HEALTH BENEFITS

Issued to

_____
(hereinafter referred to as the Company)

IN CONSIDERATION of the statements contained in the application of the Company, the Service Corporation agrees to provide Extended Health Benefits under the terms of this contract for a period of one year beginning at 12:01 a.m. Standard Time, on ..... (hereinafter called the Effective Date) and from year to year hereafter, unless this contract is terminated as provided herein. This contract is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this contract as fully as if recited herein.

IN WITNESS WHEREOF, MARITIME HOSPITAL SERVICE ASSOCIATION has caused this Contract to be signed at ..... this ..... day of ..... 19.....

MARITIME HOSPITAL SERVICE ASSOCIATION

_____
Secretary-Treasurer

ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

EXHIBIT VIII(b)

MARITIME HOSPITAL SERVICE ASSOCIATION

A NON-PROFIT CORPORATION
(Hereinafter referred to as the Service Corporation)

and

[illegible]

Issued to

[illegible]

(Hereinafter referred to as the Company)

IN CONSIDERATION of the statements contained in the application of the Company, the Service Corporation agrees to provide Extended Health Benefits under the terms of this contract for a period of one year beginning at 12:01 a.m. Standard Time, on .....
(hereinafter called the Effective Date) and from year to year thereafter, unless this contract is terminated as provided herein. This contract is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this contract as fully as if recited herein.

IN WITNESS WHEREOF, MARITIME HOSPITAL SERVICE ASSOCIATION has caused this Contract to be signed at .....
this ..... day of .....
19.....

[illegible]

EXTENDED HEALTH BENEFITS

TERMS AND CONDITIONS

ARTICLE 1 - DEFINITIONS

1. "Subscriber" means any employee of the company who is eligible for coverage for himself and dependents, if any, as hereinafter defined, and who elects coverage as provided in Article 11, Paragraph 2, of this contract.

2. "Dependent" means the Subscriber's spouse, children or legally adopted children, listed on the Subscriber's notice of election or on any supplemental notice received and accepted by the Service Corporation, provided such children or legally adopted children are not married and are under the age of 19 years. Any child or legally adopted child who marries or who attains the age of 19 years shall thereupon cease to be included under the term Dependent.

3. "Participant" means any subscriber, or dependent, as defined herein.

4. "Family Coverage" means a contract by which the Service Corporation agrees to provide contract benefits for a subscriber and his dependents.

5. "Basic Plan" means (a) the individual contract or contracts providing for hospital, surgical and medical benefits issued by the Service Corporation to each Subscriber in the group and (b) the company-recognized health plan in effect in the location where the subscriber is employed.

6. "E.H.B." means Extended Health Benefits.

EXTENDED HEALTH BENEFITS

[illegible]

ARTICLE I - DEFINITIONS

. "Subscriber" means any employee of the company who is eligible for coverage for himself and dependents, if any, as hereinafter defined, and who elects coverage as provided in Article II, Paragraph 2, of this contract.

[illegible]

or legally adopted children, listed on the Subscriber notice of election or on any supplemental notice re- [illegible] vided such children or legally adopted children are [illegible] or legally adopted child who marries or who attains the age of 19 years shall thereupon cease to be included under the term Dependent.

3. "Participant" means any subscriber, or dependent, as defined herein.

4. "Family Coverage" means a contract by which the Service Corporation agrees to provide contract benefits for a subscriber and his dependents.

5. "Basic Plan" means (a) the individual contract or contracts providing for hospital, surgical and medical benefits issued by the Service Corporation to each Subscriber in the group and (b) the company-recognized health plan in effect in the location where the subscriber is employed.

6. "Group" means [illegible]

ARTICLE II - ELIGIBILITY, ELECTION, COMMENCEMENT OF COVERAGE AND CLASSES OF COVERAGE

1. "Eligibility". Every full-time employee of the Company described below shall be eligible to elect coverage for himself and his dependents, if any, if on or after the Effective Date said employees shall have completed the period of employment with the Company set forth opposite his description and is covered under the basic plan.

DESCRIPTION OF EMPLOYEE	PERIOD OF EMPLOYMENT REQUISITE TO ELIGIBILITY

2. "Method of Election and Commencement of Coverage."

(a) Every eligible employee may elect coverage by signing and filing with the Company notice of such election on a form furnished by the Service Corporation;

(b) Coverage for all eligible employees who have elected coverage prior to the Effective Date shall commence on the Effective Date;

(c) Coverage for an employee, who elects on or after the Effective Date but before the expiration of 30 days after he has become eligible, and for his Dependents, where applicable, shall commence on the first of the second month after the date he becomes eligible or the date of filing notice of election, whichever occurs later;

(d) An employee, who does not elect within the period aforesaid, or a Subscriber, whose coverage terminates for any reason other than termination of employment, may obtain coverage only on approval by the Service Corporation;

ARTICLE II - ELIGIBILITY, ELECTION, COMMENCEMENT OF COVERAGE AND CLASSES OF COVERAGE

1. "Eligibility". Every full-time employee of the Company described below shall be eligible to elect coverage for himself and his dependents, if any, if on or after the Effective Date such employee shall [illegible] Company set forth opposite his description and is covered under the basic plan.

DESCRIPTION OF EMPLOYEE	PERIOD OF EMPLOYMENT PRECEDING ELIGIBILITY
[illegible]	[illegible]

2. "Method of Election and Commencement of Coverage."

(a) Every eligible employee may elect coverage by signing and filing with the Company notice of such election on a form furnished by the Company [illegible]

(b) Coverage for all eligible employees who have elected coverage prior to the Effective Date shall commence on the Effective Date;

(c) Coverage for an employee, who elects on or after the Effective Date but before the expiration of 30 days after he has become eligible, and for [illegible] on the first of the second month after the date he becomes eligible or the date of filing notice of election, whichever occurs later;

(d) An employee, who does not elect within the period aforesaid, or a dependent, whose coverage terminates for any reason other than termination of employment, may obtain coverage only on

(e) A subscriber who marries after the date coverage for himself commences, shall have a period of 30 days after marriage within which he may elect coverage for his Dependents. Such coverage shall commence on the first of the month preceding the marriage date, unless such date be the first of a month in which case coverage shall commence immediately. If election is made after 30 days but within 60 days of the date of marriage, the Effective Date of family coverage will be the first of the second month following election. If election is made after 60 days, the Effective Date of family coverage will be the next date determined by the Service Corporation for the reopening of the group.

3. "Classes of Coverage."

There shall be the following classes of coverage:

CLASS A Coverage for employees of the Company having individual coverage under the basic plan.

CLASS B Coverage for employees of the Company and their dependents having family coverage under the basic plan. Married women may enrol only for family rate, and may include husband and children.

...J. STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

(e) A subscriber who marries after the date coverage for himself commences, shall have a period of 30 days after marriage within which he may elect coverage for his Dependents. Such coverage shall commence on the first of the month preceding the marriage date, unless such date be the first of a month in which case coverage shall commence immediately. If election is made after 30 days but within 60 days of the date of marriage, the Effective Date of family coverage will be the first of the second month following election. If election is made after 60 days, the Effective Date of family coverage will be the next date determined by the Service Corporation for the reopening of the group.

3. "Classes of Coverage."

There shall be the following classes of coverage

CLASS A Coverage for employees of the Company having individual coverage under the basic plan.

CLASS B Coverage for employees of the Company and their dependents having family coverage under the basic plan. Married women may enrol only for family rate and may include husband and children.

ARTICLE III - BENEFITS

If in any calendar year while coverage is in force eligible E.H.B. expenses incurred by a Participant resulting from accident sustained or illness contracted during coverage exceed the total allowances, if any, under the basic plan, plus a deductible of $....., the Service Corporation will make an allowance of ..... % of the amount of such excess. E.H.B. expenses incurred in excess of the allowances under the basic plan, during the last three months of a calendar year and which have not been used to satisfy a deductible or included as part of a previous claim against the Service Corporation, will be allowed as a reduction of the $.....deductible in the immediately following calendar year. Subject to ARTICLE XIII, the total allowances hereunder to a Participant shall not exceed a maximum of $..... during the entire period of coverage of such Participant.

In the event of termination of coverage:

(a) by the Service Corporation giving notice in accordance with ARTICLE XI, Paragraphs 2 and 3, or

(b) by reason of the termination of the Subscriber's regular employment with the Company as a necessary result of illness or injury.

Then, notwithstanding such termination, E. H. B. expenses incurred by such Subscriber during the 12 months following the date thereof shall be included in the calculation of benefits. In such case, if

If in any calendar year while coverage is in force eligible E.H.B. expenses incurred by a participant resulting from accident sustained or illness contracted during coverage exceed the total allowances, if any, under the basic plan, plus a deductible of $....., the Service Corporation will make an allowance of ..... % of the amount of such excess.

E.H.B. expenses incurred in excess of the allowance under the basic plan, during the last three months of a calendar year and which have not been used to satisfy a deductible or included as part of a previous claim against the Service Corporation, will be allowed as a reduction of the $.....deductible in the immediately following calendar year. Subject to ARTICLE XII, the total allowances hereunder to a participant shall not exceed a maximum of $..... during the entire period of coverage of such participant.

In the event of termination of coverage:

(a) by the Service Corporation giving notice in accordance with ARTICLE XII, paragraphs 2 and 3, or

(b) by reason of the termination of the Subscriber's regular employment with the Company as a necessary result of illness or injury.

Then, notwithstanding such termination, E. H. B. or [illegible] in the calculation of benefits. In such case, [illegible]

coverage under the basic plan is not continued after termination of coverage hereunder, the liability of the Service Corporation hereunder in respect of the year following such termination shall not be greater than if such coverage had continued in force.

When a Participant has been under treatment, has received medical advice or has undergone diagnosis for any condition, disease or ailment within the three months prior to the commencement of coverage, E.H.B. expenses for the same or a related condition, disease or ailment shall not be included in the calculation of benefits unless incurred after an interval of three months (established by medical certificates) shall have been completed during which such Participant shall not have received medical treatment or medical advice for the same or related condition, disease or ailment.

The Service Corporation's liability with respect to E.H.B. expenses resulting from any particular accident or illness shall cease upon the expiration of five years after the date of such accident or the commencement of such illness.

When a Subscriber and more than two of his Dependents or more than three Dependents of the same subscriber incur E.H.B. expenses during any calendar year, the aggregate deductible in respect of such year shall not exceed $.....

When a common accident occurs to a Subscriber and one or more of his Dependents or to two or more Dependents of the same Subscriber, the sum of $.....

coverage under the basic plan is not continued after termination of coverage hereunder, the liability of the Service Corporation hereunder in respect of the year following such termination shall not be greater than if such coverage had continued in force.

When a Participant has been under treatment, has received medical advice or has undergone diagnosis for any condition, disease or ailment within the three months prior to the commencement of coverage, E.H.B. expenses for the same or a related condition, disease or ailment shall not be included in the calculation of benefits unless incurred after an interval of three months (established by medical certificates) shall have been completed during which such Participant shall not have received medical treatment or medical advice for the same or related condition, disease or ailment.

The Service Corporation's liability with respect to E.H.B. expenses resulting from any particular accident or illness shall cease upon the expiration of five years after the date of such accident or the commencement of such illness.

When a Subscriber and more than two of his Dependents or more than three Dependents of the same [illegible] year, the aggregate deductible in respect of such year shall not exceed $.....

When a common accident occurs to a Subscriber and one or more of his Dependents or to two or more Dependents of the same Subscriber, the sum of $

shall be deducted once only for all such Participants so injured.

E.H.B. expenses shall be deemed to have been incurred on the date on which the services are rendered or the articles are supplied.

The Service Corporation may at its option pay the amount of its allowances to the Subscriber or to the hospital, doctor, nurse or other renderer of service or supplier of articles covered hereunder.

The term "E.H.B. expenses" shall mean the following fees or charges for services rendered or articles supplied by or on the recommendation of a legally qualified physician or surgeon:

1. Charges of a legally constituted hospital for room (and not for a suite of more than one room), board and routine nursing service, but limited to a daily maximum equal to TWENTY-FIVE DOLLARS ($25.00) less the corresponding allowance under the basic plan.

NOTE: Hospital charges to the level of ward services including all charges for ancillary services are excluded under this section.

2. Fees of registered nurses provided the nurse is not an employee of the hospital, resident at the patient's home, or related to any of the Participant's family.

3. Charges for blood and blood plasma; drugs and medicines that can be obtained only on a licensed physician's prescription, prosthetic appliances,

shall be deducted once only for all such participants so insured.

E.H.B. expenses shall be deemed to have been incurred on the date on which the services are rendered or the articles are supplied.

The Service Corporation may at its option pay the amount of its allowances to the Subscriber or to the hospital, doctor, nurse or other rendorer of service or supplier of articles covered hereunder.

The [illegible]

following fees or charges for services rendered or articles supplied by or on the recommendation of a legally qualified physician or surgeon:

1. Charges of a legally constituted hospital for room (and not for a suite or more than one room), board and routine nursing service, but limited to a daily maximum equal to TWENTY-FIVE DOLLARS ($25.00) less the corresponding allowance under the basic plan.

NOTE: Hospital charges to the level of ward services including all charges for ancillary services are excluded under this [illegible]

2. Fees of registered nurses provided the nurse is not an employee of the hospital, resident at the patient's home, or related to any of the [illegible]

3. Charges for blood and blood plasma; drugs and medicines that can be obtained only on a licensed [illegible]

crutches, splints, casts, trusses, braces, oxygen and rental of equipment for the administration thereof, rental of wheel chair, iron lung, hospital type bed.

4. Charges for professional ambulance service to the nearest hospital able to provide the type of care essential for the patient and which in the opinion of the Service Corporation is justified.

5. When and where applicable, customary charges of physicians and surgeons for basic contract services rendered in the Service Corporation area, when the charges exceed the allowances provided for such services under the basic plan, to a single subscriber whose income is in excess of Six Thousand Dollars ($6,000) and for services rendered a participant covered under a family contract when the subscriber's income together with that of his Department is in excess of Eight Thousand Five Hundred Dollars ($8,500).

6. Out of Area Benefits Customary charges of physicians and surgeons for services rendered an elifible participant, only while travelling outside the area served by this Service Corporation.

If a member is entitled under any other group insurance plan to compensation for expenses of the same nature as those cofered under this Contract, the amount of compensation payable under such plan will be deducted from the E.H.B. expenses.

ARTICLE IV - EXCLUSIONS

No Participant shall be entitled to benefits in

and rental of equipment for the administration room of, rental of wheel chair, iron lung, hospital type bed.

4. Charges for professional ambulance service to the nearest hospital able to provide the type of care essential for the patient and which in the opinion of the Service Corporation is justified.

5. When and where applicable, customary charges or operations and surgeons fee basis contract rates rendered in the Service Corporation area, when the charges exceed the allowance provided for such services under the basic plan, to a single subscriber whose income is in excess of Six Thousand Dollars ($6,000) and for services rendered a participant covered under a family contract when the subscriber's income together with that of his Dependent is in excess of Eight Thousand Five Hundred Dollars ($8,500).

6. Out of Area Benefits (customary charges for physicians and surgeons for services rendered an eligible participant, only while travelling outside the area served by this Service Corporation.

If a member is covered under any other medical insurance plan or compensation for expenses of the same nature as those covered under this Contract, the amount of compensation payable under such plan will be deducted from the B.H.S. expenses.

ARTICLE IV - EXCLUSIONS

respect of the following:

1. No benefits shall be available to the subscriber or his dependents if he is entitled to receive benefits or compensation, under any law providing Workmen's Compensation benefits or any other agency or department of the government of Canada or any province thereof or municipal corporation therein, regardless of whether or not the subscriber has or has not contributed towards providing himself or his dependents with such benefits.

2. Conditions arising out of and during pregnancy except as to E.H.B. expenses incurred during a period of hospital confinement of the wife covered under "Class B" for intra-abdominal surgical procedures, pemicious vomiting or toxemia of pregnancy.

3. Dental treatment except when, as the result of an accident, natural teeth have been damaged or fractured or dislocated jaw requires setting and then only if such dental treatment is rendered within ninety days from the date of the accident.

4. Cosmetic or plastic surgery unless necessitated by accidental injuries sustained during coverage.

5. Eye refractions, hearing aids and examinations for the prescription or fitting thereof.

6. Medical care in government hospital or by a physician or surgeon employed by the government in such hospital unless a charge is customarily made by such hospital or by such physician or surgeon.

7. Mental disorders including functional nervous disorders as to E.H.B. expenses incurred while the

spect of the following:

1. No benefits shall be available to the subscriber or his dependents if he is entitled to receive benefits or compensation, under any law providing Workmen's Compensation benefits or any other agency or department of the government of Canada or any province.

regardless of whether or not the subscriber has or has not contributed towards providing him or his dependents with such benefits.

2. Conditions arising out of and during pregnancy except as to S.H.B. expenses incurred during a period of hospital confinement of the wife covered under "Class B" for intra-abdominal surgical procedures, pernicious vomiting or toxemia of pregnancy.

3. Dental treatment except when, as the result of an accident, natural teeth have been damaged or fractured or dislocated jaw requires setting and then only if such dental treatment is rendered within ninety days from the date of the accident.

4. Cosmetic or plastic surgery unless necessitated by accidental injuries sustained during coverage.

5. Eye refractions, hearing aids and examinations for the prescription or fitting thereof.

6. Medical care in government hospital or by a physician or surgeon employed by the government in such hospital unless a charge is customarily made by such hospital or by such physician or surgeon.

7. Mental disorders involving functional nervous

Participant is a registered (admitted) bed patient, under the care of a qualified psychiatrist, while receiving continuous day and night care in a public general hospital not specializing in, but equipped to provide treatment for mental disorders or diseases.

8. Alcoholism and/or drug addiction.

9. Congenital anomalies unless such anomalies occur in a child born whilst the mother is covered under "Class B".

10. Accident or illness occurring outside the limits of Canata, the United States of America, the West Indies, the United Kingdom, Eire, or the Continent of Europe unless the Participant is travelling by ferry or steamer or regularly scheduled airline plying between ports within said boundaries.

11. Injury resulting from suicide or atempt thereat, whether sane or insane.

12. Mileage to medical doctor rendering the service.

13. Hospital services to which a Participant is entitled to receive without charge under any provincial hospital legislationor that are paid for under such legislation.

ARTICLE V - NOTICES AND CLAIMS

The Service Corporation shall be liable under this Contract only provided a notice has been given and a claim has been filed in accordance with the requirements of the basic plan.

[illegible] [illegible] [illegible] a qualified physician, while [illegible] living continuous day and night care in a public general hospital not specializing in, but equipped [illegible]

diseases.

[illegible]

9. Congenital anomalies unless such anomalies occur in a child born while the mother is covered [illegible]

10. Accident or illness occurring outside the limits of Canada, the United States of America, the West Indies, the United Kingdom, Eire, or the Continent of Europe unless the Participant is travelling by ferry or steamer or regularly [illegible]

boundaries.

11. Injury resulting from athletic or sports [illegible], whether sane or insane.

12. Mileage to medical doctor concerning the [illegible]

13. Hospital services to which a Participant is entitled to receive without charge under any [illegible] municipal hospital legislation that are paid for [illegible]

ARTICLE V - NOTICE OF AND CLAIM.

The Service Corporation must be liable under this Contract only provided a notice has been given and a claim has been filed in accordance with the requirements

ARTICLE VI - INFORMATION

As a condition precedent to the providing of benefits under this Contract, the Service Corporation shall be entitled to receive from any physician, surgeon, nurse or hospital, or other party having made a diagnosis for, treated, attended, or rendered service to any Participant, or in possession of any information or records relating thereto, such information and records or copies of records as it may require in the administration of claims arising under this Contract.

ARTICLE VII - WAIVER OF LIABILITY

As a condition precedent to the providing of benefits hereunder, the Service Corporation shall be held free of any liability for any act or omission of any hospital, doctor or other person rendering any of the services hereunder provided.

ARTICLE VIII - RIGHTS NOT ASSIGNABLE

The rights of Participants under this Contract are not assignable and no assignment by a Participant whether (a) of the right to benefits hereunder or (b) of the right to payment of an allowance hereunder shall be binding upon the Service Corporation.

The coverage of a Subscriber and his Dependents shall terminate automatically if such Subscriber or any of his Dependents should aid any person in obtaining or attempting to obtain by false pretenses any benefits hereunder and the Service Corporation shall be immediately relieved of all liability for E.H.B. expenses incurred after the date of such termination.

shall be entitled to receive from any physician, surgeon, nurse or hospital, or other party having made a diagnosis for, treated, attended, or rendered service to any participant, or in possession of any information or records relating thereto, such information and records or copies of records as it may require in the administration of claims arising under this Contract.

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ARTICLE IX - CHARGES

1. The Company will pay to the Service Corporation for each Subscriber the following amounts per month for Subscribers covered under CLASS A - $_____ -- for subscribers covered under CLASS B - $_____ .

2. The subscription rates for any contract year, beginning on each anniversary of the Effective Date, may be changed by the Service Corporation by giving written notice of such change to the Company at least 60 days prior to the commencement of such contract year.

3. Membership fees are payable monthly in advance. The initial payment under this Contract is due on or before the Effective Date and the succeeding payments shall be due thereafter on the 25th of each month.

ARTICLE X - PERSONNEL RECORDS

1. The Company shall furnish to the Service Corporation during the period of this Contract such information as may reasonably be required by the Service Corporation for purposes of this contract.

2. The Company shall make available to the Service Corporation for inspection by it such payroll and other personnel records as shall have a bearing on enrolment of eligible employees and Dependents under this Contract.

ARTICLE XI - TERMINATION OF THIS CONTRACT

1. Upon default in payment of charges, in accordance with the terms of ARTICLE IX, this Contract shall terminate automatically.

ARTICLE IX - CHARGES

1. The Company will pay to the Service Corporation for each Subscriber the following amounts per month:

for subscribers covered under CLASS A - $_____ --

for subscribers covered under CLASS B - $_____ .

beginning on each anniversary of the Effective Date, may be changed by the Service Corporation by giving written notice of such change to the Company at least 60 days prior to the commencement of such contract year.

3. Membership fees are payable monthly in advance. The initial payment under this Contract is due on or before the Effective Date and the succeeding payments shall be due thereafter on the 25th of each month.

ARTICLE X - PERSONNEL RECORDS

1. The Company shall furnish to the Service Corporation during the period of this Contract such information as may reasonably be required by the Service Corporation for purposes of this contract.

2. The Company shall make available to the Service Corporation for inspection by it such payroll and other personnel records as shall have a bearing on enrolment of eligible employees and Dependents.

ARTICLE XI - TERMINATION OF THIS CONTRACT

1. Upon default in payment of charges, in accordance with the terms of ARTICLE IX, this Contract shall

2. This Contract may be terminated by the Company or the Service Corporation on any anniversary of the Effective Date by giving at least 30 days' prior notice to the other.

3. If at any time within a contract year the number of employees covered under this Contract shall be less than 25 or less than 75 per cent of the eligible employees, or if less than 75 per cent of the employees with Dependents eligible to become covered under this Contract elect and maintain coverage for such Dependents under this Contract, the Service Corporation shall have the right to terminate this Contract as of the first of any month by giving 30 days' prior written notice to the Company.

4. If the coverage provided by this Contract be replaced by the Company or otherwise in whole or in part by some other arrangement, this Contract shall be automatically terminated as of the date to which the charges have been paid, and the Service Corporation shall be immediately relieved of all liability for E.H.B. expenses incurred after the date of such termination.

ARTICLE XII - TERMINATION OF INDIVIDUAL COVERAGE

1. The coverage of every Participant hereunder shall terminate automatically on the termination of this Contract or of coverage under the basic plan.

2. The coverage hereunder respecting any Subscriber and his Dependents, if any, shall terminate automatically on the termination of such Subscriber's regular employment with the Company.

2. This Contract may be terminated by the Company or the Service Corporation on any anniversary of the Effective Date by giving at least 30 days' prior notice to the other.

[illegible]

number of employees covered under this Contract shall be less than 25 or less than 75 per cent of the eligible employees, or if less than 75 per cent of the employees with Dependents eligible to become covered under this Contract elect and maintain coverage for such Dependents under this Contract, the Service Corporation shall have the right to terminate this Contract as of the first of any month by giving 30 days' prior written notice to the Company.

4. If the coverage provided by this Contract be replaced by the Company or otherwise in whole or in part by some other arrangement, this Contract shall be automatically terminated as of the date to which the charges have been paid, and the Service Corporation shall be immediately relieved of all liability for G.M.B. expenses incurred after the date of such termination.

ARTICLE XII - TERMINATION OF INDIVIDUAL COVERAGE

1. The coverage of every Participant hereunder shall terminate automatically on the termination of this Contract or of coverage under the basic plan.

2. The coverage hereunder respecting any Subscriber and his Dependents, if any, shall terminate automatically on the termination of such Subscriber's

3. The coverage of a Dependent spouse shall terminate automatically upon divorce or legal separation from the Subscriber or annulment of the marriage.

4. The coverage of a Dependent child shall terminate automatically upon such child attaining the age of 19 years or marrying, whichever even shall first occur.

5. The coverage of any Participant shall terminate automatically when benefits totalling the maximum allowance shall have become payable hereunder in respect of E.H.B. expenses incurred by such Participant, but if such Participant is a Subscriber, coverage for his Dependents shall not be affected and may continue, subject to payment of "Class B" rates, until terminated in accordance with the provisions hereof.

ARTICLE XIII - REINSTATEMENT OF MAXIMUM ALLOWANCE

A Participant, after recovery from a disability on which a claim has been paid, may apply for reinstatement of the full maximum allowance as soon as such Participant has received $1,000 or more in benefits and can submit evidence of good health satisfactory to the Service Corporation.

ARTICLE XIV - MISCELLANEOUS PROVISIONS

1. This Contract shall not become effective unless not less than 75 per cent of all employees or not less than 75 per cent of any class or classes of employees, determined by conditions pertaining to their employment, have elected to be covered under the terms of this Agreement.

3. The coverage of a Dependent spouse shall terminate automatically upon divorce or legal separation from the Subscriber or annulment of the marriage.

4. The coverage of a Dependent child shall terminate automatically upon such child attaining the age of 19 years or marrying, whichever even shall occur.

5. The coverage of any Participant shall terminate automatically when benefits totalling the maximum allowance shall have become payable hereunder in respect of E.H.B. expenses incurred by such Participant, but if such Participant is a Subscriber, coverage for his Dependents shall not be affected and may continue, subject to payment of "Class B" rates, until terminated in accordance with the provisions hereof.

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A Participant, after recovery from a disability on which a claim has been paid, may apply for reinstatement of the full maximum allowance as soon as such Participant has received $1,000 or more in benefits and can submit evidence of good health satisfactory to the Service Corporation.

ARTICLE XIV

This Contract shall not become effective unless not less than 75 per cent of all employees or not less than 75 per cent of any class or classes of employees, determined by conditions pertaining to their employment, have elected to be covered under the terms of this Agreement.

2. Any notice given hereunder shall be sufficient, if given by the Service Corporation to the Company, when mailed to the Company at its address as it appears on the records of the Service Corporation; if given by the Company to the Service Corporation, when mailed to the Service Corporation at its principal office in Moncton, New Brunswick.

3. This Contract and the application constitute the entire Contract and the statements made in said applicati ns shall be considered representations and not warranties; no statement shall be used as a defense of any claim hereunder unless it is contained in this Contract or in the said application. No agent or representative of the Service Corporation other than a duly authorized officer is authorized to change this Contract or waive any of its provisions. All sums payable by the Service Corporation hereunder shall be payable at its principal office.

4. No action at law or in equity shall be brought against the Service Corporation for any claim hereunder unless brought within one year from the date the E.H.B. expenses were incurred.

5. The Service Corporation shall furnish, and the Company agrees to issue, certificates of enrolment to each Subscriber covered under the Contract.

6. As a condition precedent to the providing of benefits, the Service Corporation may require a transfer to the extent of the amount payable hereunder by the Service Corporation of the rights of the Participant against the persons by whose fault the accident or illness was caused.

mailed to the Company at its address as it appears on the records of the Service Corporation; if given by the Company to the Service Corporation, when mailed to the Service Corporation at its principal office in Moncton, New Brunswick.

3. This Contract and the application constitute the entire Contract and the statements made in said application as shall be considered representations and not warranties; no statement shall be used as a defense of any claim hereunder unless it is contained in this Contract or in the said application. No agent or representative of the Service Corporation other than a duly authorized officer is authorized to change this Contract or waive any of its provisions. All sums payable by the Service Corporation hereunder shall be payable at its principal office.

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5. The Service Corporation shall furnish, and the Company agrees to issue, certificates of enrolment to each Subscriber covered under the Contract.

6. As a condition precedent to the providing of benefits, the Service Corporation may require a trans[illegible] [illegible] Service Corporation of the rights of the participant against the persons by whose fault the accident or

MARITIME HOSPITAL SERVICE ASSOCIATION
Membership as at June 30, 1961

Exhibit IX

By Province

	N. B.	N. S.	P. E. I.	Nfld	Total
Population	606,000	728,000	105,000	466,000*	1,905,000
Blue Shield	148,023	24,325	11,793	17,683*	201,824
% Pop. enrolled	24.43%	3.34%	11.23%	3.79%*	10.59%
Blue Cross	130,137	115,443	11,131	14,383*	271,094
% Pop. enrolled	21.47%	15.86%	10.60%	3.09%*	14.23%

*At the request of the Dept of Health, Nfld, Association membership in that province is extended only to residents of St. John's, Grand Falls, and Corner Brook. The percentage of potential enrolment in Nfld, therefore, is a higher figure than is indicated here.

By Class of Coverage

	Group	Non-Group	Total
Number of Subscribers:			
Blue Shield - Plan #3	21,925		21,925
Blue Shield - Plan #2	7,772	780	8,552
Blue Shield - Plan #1	27,252	11,153	38,405
Blue Cross	77,194	17,734	94,928
Extended Health Benefits	3,881		3,881
Number of Dependents:			
Blue Shield - Plan #3	48,618		48,618
Blue Shield - Plan #2	15,808	1,376	17,184
Blue Shield - Plan #1	51,781	15,359	67,140
Blue Cross	153,905	22,261	176,166
Extended Health Benefits	7,490		7,490
Total Participating Members:			
Blue Shield - Plan #3	70,543		70,543
Blue Shield - Plan #2	23,580	2,156	25,736
Blue Shield - Plan #1	79,033	26,512	105,545
Blue Shield Total	173,156	28,668	201,824
Blue Cross Total	231,099	39,995	271,094
Extended Health Benefits Total	11,371		11,371

Note: Blue Shield plans refer to surgical, obstetrical, medical coverage.
Blue Cross plan refers to hospital care.

Membership as of June 30, 1961

	N. B.	N. S.	P. E. I.	Nfld	Total
Population	605,000	728,000	105,000	465,000*	1,903,000
Blue Shield	148,023	24,325	11,793	17,685*	201,824
% Population covered	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Blue Cross	130,137	115,445	11,131	14,382*	271,094
% Population covered	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

*At the request of the Dept of Health, Nfld, Association membership in that province is extended only to residence of St. John's, Corner Brook, and Gander areas. The percentage of potential enrolment in Nfld, therefore, is a higher figure than is indicated here.

By Class of Coverage

Number of Subscribers:			
Blue Shield - Plan #3	21,925		21,925
Blue Shield - Plan #2	7,722	760	8,482
Blue Shield - Plan #1	27,252	11,153	38,405
Blue Cross	77,194	17,736	94,929
Extended Health Benefits	3,881		3,881
Number of Dependents:			
Blue Shield - Plan #3	46,618		46,618
Blue Shield - Plan #2	15,808	1,276	17,184
Blue Shield - Plan #1	51,781	15,359	67,140
Blue Cross	153,905	22,261	176,166
Extended Health Benefits	7,490		7,490
Total Participating Members:			
Blue Shield - Plan #3	70,543		70,543
Blue Shield - Plan #2	23,580	2,156	25,736
Blue Shield - Plan #1	79,033	26,512	105,545
Blue Shield Total	173,156	28,668	201,824
Blue Cross Total	231,099	39,995	271,094
Extended Health Benefits Total	11,371		11,371

Note: Blue Shield plans refer to surgical, obstetrical [illegible]
Blue Cross plan refers to hospital care

(ACCRUAL BASIS)

ASSETS

CURRENT ASSETS			
Cash in Bank		482,401.39	
Investments - at cost			
Cash on Deposit	2,390.29		
Bonds (Par Value $4,506,853.71 approximate market value $4,287,573.71)	4,423,328.91		
Stocks (Approximate market value $110,100.00)	114,435.74	4,540,154.94	
Accounts Receivable - Subscribers	114,643.50		
- Others	11,865.06	126,508.56	
Accrued Investment Income		58,070.80	
Deferred Charges			
Inventories of Supplies - at cost	16,538.56		
Prepaid Expenses	3,852.37	20,390.93	5,227,526.62
FIXED ASSETS			
Land		21,798.56	
Paving		4,408.00	
Buildings		270,804.15	
Furniture and Equipment		129,158.98	
		426,169.69	
LESS - Accumulated Depreciation		132,090.69	294,079.00
			$5,521,605.62

LIABILITIES

CURRENT LIABILITIES			
Outstanding Cheques		231,194.36	
Hospitalization Claims Payable and Accrued			
Claims Received	83,911.00		
Provision for Claims not received	129,226.69	213,137.69	
Surgical and Medical Claims payable and Claims received	277,448.00		
Provision for Claims not received	445,677.94	723,125.94	
Prepaid Subscriber Dues		69,716.17	
Accounts Payable and Accured (Operating)		38,100.00	1,275,274.16
DEFERRED REVENUE			
Unearned Subscriber Dues			
Hospitalization		111,945.43	
Surgical and Medical		169,243.94	281,189.37
OTHER LIABILITIES			
Provision for Mutualization - National Contracts			1,084,903.71
SURPLUS			
Balance - January 1, 1960		2,098,602.12	
ADD - Excess of Income over Expenses for the year ended December 31, 1960	736,015.70		
- Over-provision for claims accrued in prior years	81,262.73	817,278.43	
		2,915,880.55	
DEDUCT - Under-provision for Mutualization of National Contracts in prior years		35,642.17	2,880,238.38
			$5,521,605.62

AUDITORS' REPORT

We have examined the above Balance Sheet of Maritime Hospital Service Association as at December 31, 1960 and the Statement of Plan Income for the year ended on that date. Our examination included a general review of the accounting proce res and such tests of the accounting records and other supporting evidence as we considered necessary in the circumstances.

In our opinion, the above Balance Sheet and Statement of Plan Income present fairly the financial position of the Association as at December 31, 1960 and the results of its operations for the year ended on that date, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Moncton, New Brunswick,
February 10, 1961.

Hudson, McMackin & Company

CHARTERED ACCOUNTANTS

2531

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Moncton, New Brunswick,
January 10, 1951.

Now, I am going to suggest -- you may be adjourning, I don't know -- when you come to the question period, I think if you address your questions not to me, I am only a layman, to our good friend the administrater, Mr. Doyle, and he is flanked by some experts in the particular field, and perhaps the questions may be addressed to them.

Thank you very much for your attention.

THE CHAIRMAN: Thank you, Mr. Flood.

We are going to adjourn until two o'clock, and we will want to go into your submission in some detail and there will be some questions and areas on which we are anxious to have more information. So we will continue with it at two o'clock.

------ Adjournment for luncheon, until 2 o'clock.

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--- On resuming at 2.00 p.m.

THE CHAIRMAN: The submission on behalf of the Maritime Hospital Service Association will be Exhibit No. 38, and the supplementary statement read this morning by Mr. Flood will be 38A.

--- EXHIBIT NO. 38: Submission of the Maritime Hospital Service Association.

--- EXHIBIT NO. 38A: Supplementary statement to the submission of the Maritime Hospital Service Association.

THE CHAIRMAN: Mr. Doyle, on page 12, paragraph 32, sub-paragraph 1, the sub-paragraph refers to the provision of medical health services for indigents. In the very last sentence you state:

> "We are willing to administer their membership at cost".

Could you explain what you mean by willing to administer at cost?

MR. DOYLE: Mr. Chairman, at cost of course, will be based on the type of contract or agreement that may be developed between the association, the medical profession, and the government. For example, if that type of contract is on a pure cost-plus basis, there would be no such factors in the administration costs as risk factors, reserves, and the like. There would be no enrolement expense. It would be an automatic listing

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--- EXHIBIT NO. 38A: Statement to the submission of the Maritime

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from the government to cover so many people which we are prepared to administer on a pure cost of administering the claims and sending out the cheques.

THE CHAIRMAN: That is that you would be a disbursing agent for the government?

MR. DOYLE: For that particular group.

THE CHAIRMAN: And you would charge only the administrative costs?

MR. DOYLE: That is right.

THE CHAIRMAN: And I believe you have stated in your brief that the administration costs amount to 10.2 per cent of the total revenue from subscribers, is that correct?

MR. DOYLE: That is right, sir.

THE CHAIRMAN: Are you able to tell us what portion, if any, of that 10.2 per cent is devoted to promotion?

MR. DOYLE: I would have to make a guess on that, and I prefer not to guess and use approximate figures. I would be glad to try to work that out and see that it is supplied to the Commission in a supplementary statement.

THE CHAIRMAN: Would it also be possible for you to give a breakdown of the 10.2 per cent, that is, itemized under different types of expenditures?

MR. DOYLE: We would make a cost study.

THE CHAIRMAN: So much for wages, so much for stationery?

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MR. DOYLE: We would make a cost [illegible]

THE CHAIRMAN: So much for wages, so much for stationery?

MR. DOYLE: Yes.

THE CHAIRMAN: With regard to this matter of this balance sheet which is marked as an exhibit to the brief, it makes reference in the liabilities column to provision for mutualization-national contracts. Would you explain to the members of the Commission what is meant by that entry?

MR. DOYLE: In the enrolment of a national contract, the underwriting of which is borne by several plans, possibly ten plans across the country, there is a costing of pure claims paid and there is a costing of claims incurred in a given period. Also involved in the mutualization of a contract is mutualization of losses. For example, if the Maritimes and Ontario were mutualizing a national account and we made a so-called profit, or excessive income, and there was a loss occurred in Ontario, the excess income would go to pay Ontario its losses, so these are the estimated expenditures, the expenses which this plan might incur in the enrolment of national and joint with other plans across the country.

THE CHAIRMAN: You have such accounts enrolled at the present time, do you?

MR. DOYLE: We do, sir.

THE CHAIRMAN: You also set out in your submission that you have the amount of $2,224,923.00 available for future benefits. I take it that you mean that is a reserve, is that correct?

MR. DOYLE: That is right.

THE CHAIRMAN: And is that part of

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THE CHAIRMAN: And is that part of

the surplus set out in the balance sheet, that fund?

MR. DOYLE: That is right.

THE CHAIRMAN: How long has it taken for that fund to accumulate to that extent?

MR. DOYLE: Eighteen years, sir.

THE CHAIRMAN: And do you have a regular amount each year that you set aside for that purpose?

MR. DOYLE: We hope to set aside an amount each year. Some years it is operated at a loss, in other years the experience has been more favourable, but any excessive income over a period of years is represented in that reserve.

MR. FLOOD: I think that it is pertinent to observe here that there is always a lag in trying to catch up with subscriber contracts, to overtake the increase in hospital costs, and that revision is taken annually, and sometimes there is a loss in a certain period, and it is recouped in the next month.

THE CHAIRMAN: What I am trying to get at is whether or not over an extended period of time that amount that you hold in reserve stays fairly constant. Does it average out to about the same figure, or does it fluctuate widely?

MR. DOYLE: I don't understand your question.

THE CHAIRMAN: The amount that you have available in the reserve. If you take into account that one year you pay out some, other years you accumulate some ----

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MR. DOYLE: It has been a slow growth to this extent.

THE CHAIRMAN: Has it ever exceeded the present figure?

MR. DOYLE: It does at the moment. You see, this is December 31st.

THE CHAIRMAN: Prior to December 31st 1960 had it ever exceeded the figure set out in your brief?

MR. DOYLE: I will have to refer that question to our auditor.

MR. DICK: With reference to that I would say it was at the high peak here, and it had accumulated at an accelerated rate in the last two years. In other words, we have had up to the last two, years in which there would be a deficit operation. The Blue Cross, for example, suggests that you have in reserve an amount equal to about four months of your expenses. By the way, too, I would like to say there are no ratios that would be of guide to you to say this is the right amount or this is not the right amount. If you will look at those, as another matter of interest, you probably should deduct for income purposes the $294,000.00 shown as fixed assets, to get a more or less cash position.

THE CHAIRMAN: Are adjustments made in the premium rates to take care of recurring deficits?

MR. DICK: I would say no, that there is a calculation made with regard to each type of contract, and this reserve is something that has occurred because of fortunate years in which there had been

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excesses over and above the estimate made in your calculation for your contracts.

MR. MacDOUGALL: Perhaps it might be important to mention that the reverse of that, however, has been true in the past two years, that in an attempt to off-set this, at the last two annual meetings the benefits have been improved to subscribers.

THE CHAIRMAN: Paragraph 16 on page 7, you make reference to the fact that no member of the board of trustees receives remuneration for services as board members, and there are no commission or bonus payments made to employees. You have, of course, salaried employees?

MR. DICK: That is right.

THE CHAIRMAN: If you are able to submit a breakdown of the 10.2 per cent spent on administration, if you could indicate what portion of that goes towards salaries for employees it would be of assistance.

MR. DICK: We could do that, sir.

THE CHAIRMAN: On page 13, reference is made to the problem of providing coverage for the elderly persons of the province, and reference is made to a study being made by the Economics Committee of the Medical Society of New Brunswick. Have any of you, as the directors of the Maritime Hospital Services, any suggestions or opinions as to how this segment of the population could be taken care of?

MR. DOYLE: Yes, sir. We have some suggestions that based on the establishment of some principles that probably will govern the over-all under-

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MR. DOYLE: Yes, sir. We have more suggestions that based on the establishment of some principles that probably will govern the over-all under-

writing of all health care, that some of the problems that exist now, in attempting to provide for marginally indigent or the uninsurable and the older people, can be taken care of, at least to some degree.

THE CHAIRMAN: Would you elaborate upon that for the Commission?

MR. DOYLE: Well, for example, if we go back to the original starting of our operation, Blue Shield, when it started, it started off with the community ideal of covering a whole community and everybody contributing the same amount for the same type of coverage. After the development and growth of the plan competitive practices forced us to start underwriting our coverage by segment, by class of people, by class of groups, differentiating,for example, by payroll group, direct and indirect subscribers. With the direct result that the cost is directed more accurately in their rates, the true cost of coverage. If it is possible to go back to the principle of community-wide rating, then the excess cost of covering our elderly group can be spread among the community as a whole.

THE CHAIRMAN: You did mention that you were in a competition field?

MR. DOYLE: That is right.

THE CHAIRMAN: And it would be fair to say, I believe, Mr. Doyle, that there are commercial carriers of the mutual type that provide much the same service as you do, or could provide it?

MR. DOYLE: I am afraid I cannot agree with you if you are speaking of our service type

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programme. I think our service type programme is not duplicated by any present underwriter, to my knowledge.

THE CHAIRMAN: But if they wanted to become that competitive, they could perhaps duplicate that type of contract?

MR. DOYLE: I would question that they could duplicate it without developing the same unique arrangement which we have now with the medical profession, whereby we jointly are able to offer to the public at a given premium service benefits for a given range of benefits.

THE CHAIRMAN: Do you want us to understand, Mr. Doyle, that better arrangements can be made with the medical profession through your group than through any other carrier group?

MR. DOYLE: At the moment the answer would be yes.

THE CHAIRMAN: Can you tell us why that is?

MR. DOYLE: Well, perhaps one of the reasnns why it is is first of all, we are recognized as being a non-profit operation. Our only interest is in developing a programme to serve the community. We are interested in the health of the people. That is of interest to the medical profession. They recognize that we are not promoting it for a profit. They are prepared to work with us. They have representation on the Board. They recognize that they give us guidance and leadership, and they have also recognized that we are prepared to accept that in the best interests of the public we serve.

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I think that is basically one of the reasons, among probably many, but the most important reason why they probably work with us very closely.

THE CHAIRMAN: Reference is made on page 6, paragraph 15, sub-paragraph 2, that negotiation of less than usual charges by the medical profession is one that you could carry on perhaps better than anyone else?

DR. MacDOUGALL: The answer is yes.

THE CHAIRMAN: For the reasons that Mr. Doyle has stated?

DR. MacDOUGALL: Yes.

THE CHAIRMAN: You have nothing to add to that, Doctor?

DR. MacDOUGALL: No.

THE CHAIRMAN: For example, if some one came along with the same aims as your organization, as you have outlined, and said we can administer this for 5 per cent instead of 10 per cent?

DR. MacDOUGALL: Provided the same terms that Mr. Doyle has outlined, that they give assurance that they are interested in promoting proper medical care, and having representation on their Board from the medical profession and so on, I think the medical profession would give approval to any other organization.

THE CHAIRMAN: How is your board constituted at the present time?

DR. MacDOUGALL: Twenty-eight members. Four are government representatives, one from each of the four Atlantic provinces. Nine from the

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THE CHAIRMAN: And the government members of the board are appointed by the respective governments?

DR. MacDOUGALL: That is right.

THE CHAIRMAN: How are the medical members determined?

DR. MacDOUGALL: They are elected by their medical societies at their annual meeting, and a recommendation, I presume, from their economics committee, and so on, who would recommend certain doctors who are interested in this field.

THE CHAIRMAN: And the subscriber representatives?

DR. MacDOUGALL: They are appointed only by other subscriber representatives on the board. The medical profession, the hospital people, nor the government have any voice in that.

THE CHAIRMAN: What are the mechanics of selecting the subscriber representatives?

DR. MacDOUGALL: Well, at the moment it would be that they serve at the present time a matter of three years, and each year there are two new ones

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coming up. The subscriber representatives from the board through their various areas would look over prospective members that they think would be good board members and I think that perhaps we would arrange eight or nine coming before this group who would be recommended.

MR. DICK: I would like to say something about the 10.2 per cent and the dangers of using this sort of measure and ratio. There is another one which is probably more effective, and which would be per contract, and also the fact of thinking back before, when this organizatinn was dealing with premiums which were much higher, say, for hospital care in terms of administrative costs, you get a lower ratio. Immediately you begin tofinance a different type of hospital care with lower premiums, your administration costs and paper work and that sort of thing are the same. If you are making comparisons with insurance companies, you have a large volume of income from investments compared with over-all costs. I thought that because of the line of questioning this 10.2 factor should be brought out.

Another factor is that in the Maritime provinces we have a higher expense ratio in handling sales of almost anything.

MR. DOYLE: As an example, if your premium and your costs per contract of administering the contract is, say, 50 cents as an example, and the premium is $5.00, you have a 10 per cent operation, but if your premium goes to $10.00 because of increased costs of items rather than increased unit of service, then your operating cost is 5 per cent.

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THE CHAIRMAN: Mr. Doyle, as you operate now -- and we are concerned with two phases: your present operation, and what it might be in future -- as you operate now, you take selected risks; is that your over-all principle?

MR. DOYLE: I am not too sure of what you mean by "selected risk".

THE CHAIRMAN: Those above a certain age; those below a certain age?

MR. DOYLE: Well, to a point: for example, we will go into a firm and if there are twenty-five or a hundred and twenty-five, it doesn't make any difference ----

THE CHAIRMAN: All right. I am going to exclude your groups for the moment. That is one of your primary contract areas -- group areas?

MR. DOYLE: Yes.

THE CHAIRMAN: And in those you take all within the group?

MR. DOYLE: Group risk.

THE CHAIRMAN: Yes, and you carry them on after they cease employment?

MR. DOYLE: That is right.

THE CHAIRMAN: We leave that group area, which, after all, is the smaller segment of the public; isn't it?

MR. DOYLE: That is right.

THE CHAIRMAN: We move out into the larger area: there do you have any selection?

MR. DOYLE: We do have the age

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MR. DOYLE: That is right.

THE CHAIRMAN: We move out into the larger area: there do you have any selection?

MR. DOYLE: We do have the age

limit for individual applications of sixty years of age.

THE CHAIRMAN: Sixty?

MR. DOYLE: That is right.

THE CHAIRMAN: And have you an age limit on the other end -- children?

MR. DOYLE: Nineteen years of age for children; the end of the year in which they become nineteen.

THE CHAIRMAN: Is it the same premium in the period from nineteen to fifty-nine, or from nineteen to sixty?

MR. DOYLE: Nineteen to sixty years of age is the same premium, and it is the same premium thereafter. In other words, there is an individual direct pay premium which applies to anybody that is on direct pay, regardless of their age -- supposing they are eighty years of age.

THE CHAIRMAN: But they had to be in there before they were sixty?

MR. DOYLE: Yes, they must have established their contract before they became sixty years of age.

THE CHAIRMAN: What is the percentage of the population of New Brunswick that you now cover?

MR. DOYLE: Approximately 24.2 per cent.

THE CHAIRMAN: So we have got 75.8 per cent of New Brunswick not covered?

MR. DOYLE: That is not quite so. We have about 24.2 enroled by our organization; I would

limit for individual applications of sixty years of age.

THE CHAIRMAN: Sixty?

MR. DOYLE: That is right.

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say there would be another, probably, fifteen per cent by insurance.

THE CHAIRMAN: I am just talking about your organization for the moment.

MR. DOYLE: I am sorry. That would be right, sir.

THE CHAIRMAN: And of the 24.2, what is the ratio of group to non-group?

MR. DOYLE: Approximately 70 per cent group, sir, and thirty per cent non-group.

THE CHAIRMAN: Within this, and exluding the group you would insure between nineteen and sixty, are there any restrictions on that? Must they be insurable medically?

MR. DOYLE: They must be insurable medically, but we accept approximately 98 per cent of all the applications that are received for non-group membership. That is our experience in the past.

THE CHAIRMAN: But it is known before you apply that you are expected to be insurable medically?

MR. DOYLE: That is right.

THE CHAIRMAN: And you say there is an equalized premium; you pay the same premium at twenty as at fifty-nine?

MR. DOYLE: That is right.

THE CHAIRMAN: If we move forward, as I understand your brief, you would propose covering the entire population of New Brunswick from infants to the oldest; is that right?

MR. DOYLE: That is right, sir.

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THE CHAIRMAN: If we move forward, as I understand your brief, you would propose covering the entire population of New Brunswick from infants to the oldest; is that right?

THE CHAIRMAN: And those who are physically fit and those who are not physically fit, and regardless of their present condition?

MR. DOYLE: That is right, sir.

THE CHAIRMAN: And do you propose to include the mentally ill as well?

MR. DOYLE: Well, as far as the mentally ill are concerned, I am not too certain how far I could suggest that we provide coverage because at the moment approximately 90 per cent of the cost of care for the mentally ill is borne by the provincial government. We are in a transition period where treatment for mentally ill -- many think it should be treated as an acute illness in a general hospital. We have no specific opinions on that because we feel that is definitely a medical matter, but until such time as medical care by qualified psychiatrists is more generally available in the province we would not feel justified in establishing a premium to which all the people in the province contributed if services are available in very few areas. Most of the psychiatrists at the moment in the province are with the Department of Health.

THE CHAIRMAN: So that your answer is that you do not propose to include mental illness at this time?

MR. FLOOD: We can't sell a commodity that we can't deliver.

THE CHAIRMAN: Well, therefore, you don't propose to include it? I am quite prepared to accept your answer as "No".

THE CHAIRMAN: And do you propose to include the mentally ill as well?

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MR. DOYLE: But our answer is not "no". That is our reason.

THE CHAIRMAN: Well, it is "yes"?

MR. DOYLE: I don't think it is "yes".

DR. MacDOUGALL: We are not opposed to covering it if this becomes a need for the people.

THE CHAIRMAN: I am not initiating an argument or trying to get you into difficulty. I just want to find out what your position is in fact.

MR. DOYLE: I am sorry, I don't find it possible to answer the question categorically "yes" or "no", but I do feel that if in the wisdom of medicine that tomorrow mental care is going to be treated as an acute illness in a general hospital, then we as a service to the people should cover it.

THE CHAIRMAN: Well, I will have to put it to you this way, and I am referring you to page 13 of your brief, the last two lines: You are referring to a survey that is going on and you say, "we should welcome the adoption of standards governing the benefit offerings, regulations, and underwriting practices which would enable M.H.S.A. to extend coverage to those who currently have difficulty in qualifying for membership under present regulations." I have no doubt the mentally ill have difficulty in qualifying for membership, have they not, under present regulations?

MR. DOYLE: No; we provide coverage for mentally ill up to seventy days. We recognize there is a need for the coverage. It is just a question of

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how universal we wish to make it.

THE CHAIRMAN: You go on to say, "thus an adequate health care programme could be made available to every resident regardless of state of health or age."

MR. DOYLE: That is right, sir; we believe that.

THE CHAIRMAN: In that statement do you want the Commission to accept the proposition that you are going to include, that you want to include mental health patients, or that you want to exclude them, in that statement?

MR. DOYLE: Within the statement, sir, I think, and I must repeat, that if medicine should feel that mental illness is to be treated as an acute illness in a general hospital, then it becomes a benefit. If the present situation continues where the government is going to provide the care and pay 90 per cent of the cost, I think the question would be comparable, if I may compare it, to asking me if we propose to cover T.B.

THE CHAIRMAN: Yes, that was my next question.

MR. DOYLE: There isn't any reason to cover it: the service is already provided. Why put it into the care of premium coverage? We see no reason for it.

THE CHAIRMAN: Would you give consideration to this, by way of questioning, that you say the government -- and that means the taxpayer?

MR. DOYLE: That is right.

THE CHAIRMAN: You go on to say, "thus an adequate health care programme could be made available to every resident regardless of state of health or age."

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THE CHAIRMAN: Would you give consideration to this, by way of questioning, that you say the government -- and that means the taxpayer?

THE CHAIRMAN: So that the taxpayer is covering that segment of the population?

MR. DOYLE: Yes.

THE CHAIRMAN: And is it the view of your association that the taxpayer should continue to bear the cost of these two segments?

MR. FLOOD: The administration of it may be incorporated in the operation of our plan, but we do not provide the service. This organization provides the finances to pay for the service, and the service is currently not available -- the medical service.

MR. DOYLE: I think we must be prepared, Mr. Chairman, to consider our organization extremely flexible and move along with the changes in treatment and care of the different illnesses. I can see very well that within ten years the number of T.B. patients in the province would be so small that they would not have sanitoriums for T.B., and they would treat them in isolated sections of general hospitals, and I think when it reached that stage we would have to take a look at our contract and revamp it to suit that particular situation and cover those people.

THE CHAIRMAN: What would be the position of your association in a comprehensive programme of medical services insofar as covering everybody is concerned in terms of an equalized premium?

MR. DOYLE: An equalized premium meaning that everybody in the community pays the one rate for membership?

THE CHAIRMAN: Correct.

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THE CHAIRMAN: Correct

MR. DOYLE: We would welcome that arrangement.

THE CHAIRMAN: And assuming that some of the community might not be able to pay that equalized premium, have you any suggestion to make as to how the premiums of those unable to pay would be paid?

MR. DOYLE: I think for those who can't support themselves and are unable to pay, they should be the burden of the community, and speaking of the community, that is government. Therein lies government responsibility to these people who are unable to support themselves. We have them in every form and many forms: community chests and many forms of help for the so-called indigent, and we think the government should pick up the tab for that particular segment of the population.

THE CHAIRMAN: How would you identify those?

MR. DOYLE: I think probably there is only one way of identifying them. First of all, I think there are degrees of indigency, and there are different types. There are those who are chronically indigent and those who are indigent because of an acute catastrophy at the moment, and there are those who become indigent probably because of circumstances -- that is, a bad year for the farmer in certain localities -- and that type of thing. I think there is only one way to handle and service the indigent, and that is to identify those who are already identifiable by government who establish rolls and listings. For those not so identified,

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I think there should be some form of means test whereby these people can be identified through the welfare board and helped at municipal level. I think that is the manner. There is no such pattern I know of that would equitably identify an indigent. For example, if you were to take the income tax and you would say everybody making an income tax return should have the information available, we don't think that is very practicable because the income tax is confidential information and it is not readily available. If you were to put it on salary, salary is not an equitable thing because two people making the same salary do not have the same obligations. The real income of the two may be very different. Therefore, you must know the circumstances at the local level, and I think the only way to handle that is a means test.

THE CHAIRMAN: And you would leave that to government?

MR. DOYLE: I don't think it should be government, sir.

THE CHAIRMAN: Who would do it?

MR. DOYLE: I think it should be an autonomous group -- a welfare board appointed at municipal level.

THE CHAIRMAN: How many would there be of such in the Province of New Brunswick?

MR. DOYLE: Well, you have one for each county, let us say, and there could be two or three people who would, I am sure, accept that responsibility.

THE CHAIRMAN: Thank you very much,

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COMMISSIONER BALTZAN: Mr. Flood and gentlemen, I have not read before a clearer exposition of the non-profit in medical care and hospital benefits organizations, and I pay you that compliment because you have enlightened me personally a great deal. We have heard already that your board of trustees is composed of twenty-eight members, and there are nine who are medical men, and I note on page 5, paragraph 15, your generous praise for the assistance and co-operation by the medical profession, and it follows through to numbers 1, 2, 3, 4, and 5, and to the following page, which I shall not read, and I presume that this is a question which is voiced by the non-medical chairman of the trustees as the majority opinion of the contributions made.

My question is going to be directed in this way, and you may answer it if you care to, or not answer it at all. I direct it to you because you are experienced lay people in medical care services. My question will deal briefly, I hope, with the matter of doctors setting their own tariffs and doctors setting their own standards of quality. Sometimes there is praise and sometimes there is criticism. More directly, are doctors the most competent and reliable people to set the quality and standards of medical practice, and if you want me to make it a little clearer, please ask me. Who else would you depend on to set the quality of the standards and practice?

MR. FLOOD: My answer would be, who but the doctor is competent to judge the adequacy of

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MR. FLOOD: My answer would be, who but the doctor is competent to judge the adequacy of

medical care? As a layman, I am not qualified.

COMMISSIONER BALTZAN: In other words, it is their duty, responsibility, and they are to be depended upon?

MR. FLOOD: Yes, they must police and regulate their own profession. We can't regulate it.

COMMISSIONER BALTZAN: In other words, in answer to the same question, might it be that lay groups alone could not be as good a judge or better judge?

MR. FLOOD: The doctors alone, you mean?

COMMISSIONER BALTZAN: No, the people -- the committees, the groups alone could not be as good a judge of setting the standards of quality of medical care?

MR. FLOOD: The very fact we have set up an organization, set up as it is by hospital authorities, medical representatives, lay representatives and government is the answer to that question. We believe the joint operation of these four sections is the best method of administration.

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COMMISSIONER BALTZAN: I hope you don't think my question is irregular, because you will find this question posed in some editorials and some papers, and sometimes questions by people as to who is in the best position to judge the quality and the standards.

MR. DOYLE: We have no question of that in our mind whatsoever.

COMMISSIONER BALTZAN: Thank you for your answer. Then with regard to the matter of tariffs, charges, are the doctors in the best position to know what is a proper, adequate, legitimate, fair charge for the kind of service that medical treatment requires?

MR. DOYLE: We feel, sir, that that is so, and it is our experience that working with the profession as a group they are prepared to think as a group, sacrificing at times their personal preferences for wishing to have certain tariffs, except the tariff which is agreed to and accepted by all the members of the participating doctors.

COMMISSIONER BALTZAN: That, gentlemen, answers my questions. Thank you.

COMMISSIONER STRACHAN: Mr. Chairman, regarding the means test board that has been suggested, first of all, I would like to ask how long would an individual be put in a certain category? Would he be there for the insuing year as an indigent or as a paying subscriber, or could his category be changed from time to time? Further, where is that line of demarcation between the indigent and the self-supporting going to be drawn, and how are you going to control it? Wouldn't

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there be a tendency for it to gradually creep up with more becoming indigent?

MR. DOYLE: I would hesitate to think so. I think it would creep up if they were made available without a means test and just a matter of application to, say, a government body, without evidence of need. But when you have a group at board level who know the circumstances of the case, and in some cases have the doctor's knowledge of the case, I wouldn't think that a name going on the list should stay for anything like a year. I think it is a matter that should be reviewed every month, probably, because the circumstances will change very rapidly; he is employed today, he is working tomorrow, he has an income.

COMMISSIONER STRACHAN: How would you contend with the individual who felt an injustice was being put on him because his neighbour is in the indigent class and he is possibly living in a better home, driving a better car than the one who is self-supporting?

MR. DOYLE: Well, sir, I think one of the things you would have to take into consideration, you have to believe that the type of board you would set up would be autonomous, would attempt to do an honest job, and I don't think if you had a situation as you describe, where a person owns their own home and driving a car or something of that nature could be classed as an indigent even temporarily; he would have to use his established credit, and I think an indigent would be a person without any means. As far as pleasing the public goes, I have no conception how you would go about it.

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No matter what you would do, if you made it free to all the people, there would be many who would be unhappy, and I think the best thing to do is attempt to do an honest job and do it.

COMMISSIONER STRACHAN: You mentioned community chest. Do you suggest that government should take over all community chests?

MR. DOYLE: No. I gave it as an example of there being a need to help those who need help.

MR. FLOOD: And willingness.

MR. DOYLE: And the public's willingness to do their part.

COMMISSIONER VAN WART: Mr. Doyle, you may want to consider this question and submit it in your subsequent brief to the Commission. In your experience and realizing the economic position of these four provinces and your experience in collecting premiums, striking rates in these provinces, could you tell the Commission what would be the maximum premium which the individual of these provinces could bear without working a hardship on them? I realize there is a certain point to where the premium could go and then your sales would fall off. I would like to know the maximum range that the people in this province could bear, and if you are not in the position to answer that now you could answer it in the subsequent submission.

MR. DOYLE: I prefer to give it some thought, Mr. Chairman, and try to arrive at something rather than make an guesstimate.

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COMMISSIONER McCUTCHEON: First turning to page 6 of your brief, paragraph 4, you say:

"That the medical profession has manifested a keen interest in maintaining a high standard of medical care. For example, the societies have taken the position that payments for x-ray services be made only to qualified radiologists; that payments for electrocardiograms be made only to specialists in internal medicine,"

and so on. Turning to the chart which was submitted in the government brief this morning, and looking at hospital regions, I find that there is one region not too far from Fredericton, according to the map, in which there are no specialists and radiologists. In internal medicine there are four out of the eight regions in which there are no specialists now. What does the statement mean in those circumstances? What happens to the people in those regions?

DR. MacDOUGALL: Mr. Chairman, first of all, somebody outside of the province looking at a map would not necessarily get a picture reflecting what happens in medicine in this area. For example, you might not be familiar with the fact that while you may not have a x-ray radiologist, say, thirty miles from Fredericton, they do have the benefit of the service of a radiologist going out from Fredericton.

COMMISSIONER McCUTCHEON: Frequently?

DR. MacDOUGALL: Yes, and they have this around the province, and while there may not be one living in that area, they do have the services of a

COMMISSIONER MOUNTCHESHON: Please

keep interest in maintaining a high standard of medical care. For example, the societies have taken the position that payments for x-ray services be made only to qualified radiologists, that payments for electrocardiograms be made only to specialists in internal medicine," and so on. Turning to the chart which was submitted by the government belt this morning, and looking at hospital regions, I find that there is one region not too far from Fredericton, according to the map, in which there are no specialists and radiologists. In northern medicine there are four out of the eight regions in which there are no specialists now. What does the statement mean in those circumstances? What happens to the people in those regions?

Dr. MacDONALD: Mr. Chairman, first of all, somebody outside of the province looking at a map would not necessarily get a picture relating what happens in medicine in this area. For example, you might not be familiar with the fact that while you may not have a x-ray radiologist, say, thirty miles from Fredericton, they do have the benefit of the service of a radiologist going out from Fredericton.

Dr. MacDONALD: Yes, and they have a

while around the province, and while there may not be one

living in that area, they do have the services of a

radiologist.

COMMISSIONER McCUTCHEON: Let's take internal medicine where the hospital hasn't a specialist.

DR. MacDOUGALL: There is no reason why an electrocardiogram could not be taken and sent into the hospital to be read.

COMMISSIONER McCUTCHEON: Providing there are the facilities for taking the electrocardiogram.

DR. MacDOUGALL: Usually that would be a hospital facility.

COMMISSIONER McCUTCHEON: Do I understand that the general practitioner who has long years in practice cannot take his own x-ray and his own machines and situate it in one of these remote areas, read the plates?

DR. MacDOUGALL: They are not paid.

COMMISSIONER McCUTCHEON: Leaving out your group coverage, I am an individual, how do I become enroled in your system, assuming that I don't walk into your office, and my experience in the insurance business is that people don't walk into the office.

MR. DOYLE: At regular intervals we advertise through radio, we give information in circulars to employees, and they take these and tell their neighbours. We send it to rural agricultural areas, and so on. We make an attempt to disseminate the information, but it is not financially sound to have, may I call it, a door knob method of giving the information.

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COMMISSIONER McCUTCHEON: You don't have salesmen?

MR. DOYLE: We have salesmen, but they are group enroled.

COMMISSIONER McCUTCHEON: Are they paid?

MR. DOYLE: No commission.

COMMISSIONER McCUTCHEON: But I presume if they don't work they ---

MR. DOYLE: That is right, sir.

COMMISSIONER McCUTCHEON: Much like a commission.

I would like to turn to section 4 (b). Now, as I understand it, this is what you call a service contract. What it means is if I select a physician who is a participant in this scheme, then it is a true service contract.

MR. DOYLE: That is right.

COMMISSIONER McCUTCHEON: But if I of my own free choice select a physician who is not in the scheme, then it becomes an indemnity contract?

MR. DOYLE: Yes, for services in the contract.

COMMISSIONER McCUTCHEON: I am looking at the inside page, and I note that there are roughly -- there are nineteen numbered clauses, and some of them have a's, b's and c's in them, and they take up nearly a page of limitation of services and services not included. I am not quarreling with these limitations or exclusions, but would you say that your limitations

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and exclusions are more limiting and more exclusive or less limiting and less exclusive than the commercial carrier?

MR. DOYLE: First of all, with respect to limitations, I think if you will review the limitations you will find, for instance, that the first limitation has to do with mental illness, and the plan allows up to seventy days treatment, thirty days for admission ---

COMMISSIONER McCUTCHEON: Are we looking at the same document?

MR. DOYLE: That is 4(b), sir.

COMMISSIONER McCUTCHEON: I should have mentioned also waiting periods.

MR. DOYLE: Well, perhaps I will start at article 6 and go along with the waiting periods. Now, the reason behind the waiting periods is simply this. It is a co-operative pooling of money of those participating, and there is a waiting period because if you did not have a waiting period the people would join when they had an immediate use for care.

COMMISSIONER McCUTCHEON: Can you tell me -- you are in a competitive business, you said -- are your waiting periods, limiitations and exclusions specifically the same as those of the commercial carriers with whom you compete?

MR. DOYLE: I think they are formidable but I think they are comparable in price. I think one of the reasons for that is this, that we attempt to give the subscriber what he wishes. Article

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7 is not actually an exclusion, it is a statement that we will not pay for services rendered to him where there is no cost.

COMMISSIONER McCUTCHEON: Your waiting periods and exclusions and limitations are comparable to those of the commercial carriers with whom you are in competition?

MR. DOYLE: The better commercial carriers, yes.

COMMISSIONER McCUTCHEON: Mr. Chairman, I wonder if the association could file with us, say, ten years comparable balance sheets and operating statements. There are no operating statements before us.

MR. DOYLE: We can supply that. We would be happy to.

COMMISSIONER McCUTCHEON: Thank you very much.

THE CHAIRMAN: I just want to come back to this matter. You have mentioned covering mental illness for seventy days twice. Is it not a fact that you would only cover mental illness which did not exist at the time of enrolment?

MR. DOYLE: No, sir.

THE CHAIRMAN: What does this mean in article VI, (b) (ii)? You say "limitation of services", of article VI. Then you say that services shall be available only when the participant has been covered under this contract for six consecutive months.

MR. DOYLE: That is right.

THE CHAIRMAN: For any condition,

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MR. DOYLE: That is right.

THE CHAIRMAN: For any condition,

disease or ailment. That would include mental illness, would it not?

MR. DOYLE: Yes. There would be a six-month waiting period for any condition which was established as a pre-existing condition.

THE CHAIRMAN: Including mental illness?

MR. DOYLE: Yes.

THE CHAIRMAN: And the contract which Commissioner McCutcheon was referring to contains a termination of rights to benefits clause, that is Article XXI. That gives your company, does it not, your association, the right to terminate the contract on one callendar month's prior notice?

MR. DOYLE: In practice we have never terminated a membership. But, this is designed to allow us to terminate a contract. For example, we might have had a contract in operation and five years from now we may want to change this contract and improve it, and so on, and we would write to our subscribers and say, this contract is being cancelled but you are offered membership in the new contract. This permits us to terminate the contract as a contract, but he retains his membership in the plan.

THE CHAIRMAN: Can you point out anything to me in 4(b) which shows that?

MR. DOYLE: That is our practice, sir.

THE CHAIRMAN: No, but in the document?

MR. DOYLE: Yes. There would be a six-month waiting period for any condition which was established as a pre-existing condition.

THE CHAIRMAN: And the contract which Commissioner McCutcheon was referring to contains a termination of rights to benefits clause, that is Article XXI. That gives your company, does it not, your association, the right to terminate the contract on one calendar month's prior notice?

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COMMISSIONER FIRESTONE: Mr. Flood, this is a very comprehensive brief. It contains a lot of factual information. It will be very helpful to the Commissioners as well as to our research staff. Our research staff is presently engaged in mapping out a study to examine the workings of different medical care plans. I take it, sir, that if our research staff will come to your organization for additional, detailed and specific information, we can have that co-operation?

MR. FLOOD: Most assuredly, sir.

COMMISSIONER FIRESTONE: That will enable me to concentrate my own questions on questions of principles, and perhaps I might address some of those to Mr. Doyle.

In paragraph 3 of your summary, under B you say that you operate a comprehensive service type of medical contract. What does comprehensive mean in this context, sir?

MR. DOYLE: Comprehensive, as we use it in this particular contract, applies to the terms and conditions of the contract set forth in 4 B which we have just reviewed a moment ago, which in practice provides a benefit for practically every service rendered by a general practitioner.

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COMMISSIONER FIRESTONE: Thank you. I would like to refer for a moment to the answer which you gave in this connection to a question posed to you by one of my fellow Commissioners, when you made a comparison with the services rendered by commercial carriers. Is it true that limitations and exemptions vary among different commercial carriers?

MR. DOYLE: They do, sir.

COMMISSIONER FIRESTONE: Would you say that if the comparisons were made between the limitations and exceptions which your plan calls for, would the limitations and exemptions provided for by all carriers, those that you call the good ones and those that you call not so good, that your terms are more favourable to the subscriber of your plan than the terms offered to policyholders of all commercial carriers taken as a group?

MR. DOYLE: We are satisfied that that is so, sir, and I think probably that can be substantiated by the fact that our return in benefits to that of the subscriber's dollar is substantially greater than the average of the insuring bodies.

COMMISSIONER FIRESTONE: Would it be possible inthe supplementary information that you will provide, to offer the Commission the evidence substantiating this claim?

MR. DOYLE: We would be happy to, sir.

COMMISSIONER FIRESTONE: Thank you very much. Another question which was addressed to you

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COMMISSIONER FIRESTONE: Thank you very much. Another question which was addressed to you

by our counsel in connection with the comparative effectiveness of medical care plans offered by non-profit organizations and profit organizations, would it be correct to say, based on eighteen years of your experience, that in your case it has been proven that non-profit operations based on consultation and co-operation with physicians, the public, and the government, can offer a better and more efficient health service than a plan operated by commercial carriers as a group on a profit basis?

MR. DOYLE: We are convinced that that is so, sir.

COMMISSIONER FIRESTONE: Thank you. May I turn now to this question of a comprehensive plan again, or comprehensive service again. Have you had complaints from physicians since you have introduced this comprehensive service plan that there is much misuse of that plan through overloading physicians with unnecessary visits, or unnecessary requests for medical care?

MR. DOYLE: The answer to that, sir, would be no. As a group and as a body, I think that our experience in the operation of the plan is as we might expect it to be. I think that the medical profession, as a group, have given us evidence that they are prepared to control overutilization if it should appear in individual and isolated cases.

COMMISSIONER FIRESTONE: But you have had no large number of complaints that this exists in practice, because you have provided an over-all

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COMMISSIONER FIRESTONE: But you have had no large number of complaints that this exists in practice, because you have provided an over-all

service, and you either have had a lot of complaints or you haven't?

MR. DOYLE: We haven't.

COMMISSIONER FIRESTONE: Therefore your experience has been favourable and encouraging, based on whatever number of years you have had that scheme in operation?

MR. DOYLE: That is right.

COMMISSIONER FIRESTONE: You are saying that you are considering the extension of the programme on a much more comprehensive basis. If such an extension of service were to take place for the province of New Brunswick as a whole on a universal and comprehensive basis, would, in your opinion, the same principles of experience apply, that there would not be a substantial misuse of that comprehensive plan?

MR. DOYLE: I don't think that there would be a misuse, but there would be an increase in use, because your exposure would be entirely different.

COMMISSIONER FIRESTONE: Well, that of course would be based on medical requirements?

MR. DOYLE: That is right.

COMMISSIONER FIRESTONE: There would be an increased use because there are more people that are ill, who need more medical attention, but we are dealing here with one complaint that has been suggested to us by some people that when you have a comprehensive scheme that people are apt to misuse that scheme substantially, and thereby defeat its purpose. You are one of the few people that have had experience

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with it, and I am taking from what you say that this has not been true from your experience, that people don't like going to a doctor if they can help it?

MR. DOYLE: I wouldn't go all the way along on that. I think our position unique for this reason, first of all, a non-profit organization such as ours, where we work with people in groups and do some educational work, people are prepared probably to accept certain contract limitations, if you like, for the over-all good of the operation. I think this with some sense of conviction, that if, for example, the Dominion Government were paying and providing this service, that the utilization would be different, because the individual, neither the provider nor the receiver of the service would have the same personal interest in its success or loyalty in its usage.

COMMISSIONER FIRESTONE: May I address a question to your medical adviser. Do you feel that since this plan has been in operation, and you speak now as a physician who has dealt with people, that people have over-utilized, or made unnecessary use of this sort of service which is now available to them?

DR. MacDOUGALL: We not only are in a position to answer that, but we have sought that information, we were warned about this, and looked into it as you are doing. To date we can say that there has been no trend to over-utilizing of the services.

COMMISSIONER FIRESTONE: And would you say as a medical expert in this field that if your plan were extended to the province as a whole that you

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COMMISSIONER FIRSTBROOK: Can what you say as a medical expert in this field that if your plan were extended to the province as a whole that you

would expect to have a similar experience?

DR. MacDOUGALL: The province as a whole, as we see it, at the present time I would expect a similar experience.

COMMISSIONER FIRESTONE: Thank you very much. I would like to turn now to this question, Mr. Chairman. How many non-profit plans are in operation in the Atlantic provinces?

MR. DOYLE: Two, sir.

COMMISSIONER FIRESTONE: Would it be more efficient administratively speaking to have one plan?

MR. DOYLE: I am not certain that I can answer that, but on the surface there would appear to be a possibility of a savings.

COMMISSIONER FIRESTONE: And I take it the saving would presumably be largely in the field of administrative costs?

MR. DOYLE: Strictly.

COMMISSIONER FIRESTONE: Are your two groups considering the possibility in the interest of increasing efficiency and the interest of providing the best and most economic service to the people of New Brunswick, of the possibility of developing one plan?

MR. DOYLE: Well, sir, it is a type of thing that probably is under continuous study wherever business is in operation. I'm sure we have thought about it. It has been discussed but nothing has developed from it.

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COMMISSIONER FIRESTONE: Is some consideration being given to such a possibility at this time?

MR. DOYLE: Yes, sir.

COMMISSIONER FIRESTONE: As and when this consideration reaches the stage where you feel you can make decisions, would it be possible for you to communicate to the Commission what those decisions are, and the reasons for them?

MR. DOYLE: We will be happy to do so.

COMMISSIONER FIRESTONE: You have been most co-operative, sir. I have only one last small matter to raise, and that is you refer on page 13 to a study in which you have examined M.H.S.A. claims totalling nearly half a million dollars, and you have developed certain conclusions based on this study. Could this study be made available to the Commission?

MR. DOYLE: Yes, but if the Commission is going to use a study of this type, we should have an explanation of the basis and foundation on which it was built.

COMMISSIONER FIRESTONE: Would you let us have the study and any commentary you care to?

MR. DOYLE: We would be happy to.

DR. MacDOUGALL: May I qualify an answer I gave to the Commissioner when he asked if I would expect on a comprehensive service province-wide whether we would expect an increase in the utilization of services. I would stick to my answer that I would

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COMMISSIONER FIRESTONE: You are thinking in terms of a plan where the medical profession and lay people have a say in the administration of the plan?

DR. MacDOUGALL: Right.

COMMISSIONER FIRESTONE: My question was based on that plan.

COMMISSIONER McCUTCHEON: And I take it that you think your experience would be substantially different if it were a so-called free plan, supported by the government through taxation?

DR. MacDOUGALL: I have no hesitation in saying so.

THE CHAIRMAN: Where you said covered after the nineteenth year, is there any coverage for those under nineteen?

MR. FARMER: Under the family contract there is.

THE CHAIRMAN: Are there any exclusions, any medical exclusions, because of a congenital condition, or anything of that kind in one of the children?

MR. DOYLE: We did have an exclusion and we are very happy to say that one of the improvements we made effective last July was the removal of that

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MR. DOYLE: We did have an exclusion and we are very happy to say that one of the improvements we made effective last July was the removal of that

exclusion. It is now available.

COMMISSIONER STRACHAN: Have you any coverage at all for those over sixty, other than those who were in the contract prior to that age?

MR. DOYLE: Not at the moment, sir, but we do have a study underway, and it is our hope and belief that we will have a programme available for the people of all ages, I think I can say, within the next twelve months, and probably within the next few months.

DR. MacDOUGALL: This study is carried on with the co-operation of the medical profession. They are contributing to this study.

THE CHAIRMAN: Thank you very much, gentlemen. You have been very helpful, and very informative.

MR. FLOOD: Thank you, Mr. Chairman, and members of the Commission for your very courteous hearing.

THE CHAIRMAN: Next we will hear from the New Brunswick Psychiatric Association.

THE SECRETARY: That will be Exhibit No. 39.

--- EXHIBIT NO. 39: Submission of the New Brunswick Psychiatric Association.

evaluation. It is now available.

COMMISSIONER STRACHAN: Have you any coverage at all for those over sixty, other than those who were in the contract prior to that age?

MR. FOYLE: Not at the moment, sir, but we do have a study underway, and it is our hope and belief that we will have a programme available for the people of all ages, I think I can say, within the next twelve months, and probably within the next few months.

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SUBMISSION

of

THE NEW BRUNSWICK PSYCHIATRIC ASSOCIATION

APPEARANCES:

Dr. R. G. Forsyth,

Dr. W. W. Black,

Dr. J. R. Handforth.

DR. FORSYTH: Mr. Chairman, members of the Commission, ladies and gentlemen, first I would like to introduce ourselves. I am Dr. Robert Forsyth. I am a psychiatrist in private practice. On my right is Dr. W. W. Black, who is a psychiatrist and clinical director of the provincial hospital in Lancaster, and on my left is Dr. James R. Handforth, who is also a psychiatrist, he is in charge of the psychiatric section of the D.V.A. hospital in Lancaster.

I would like to apologize for the form of our brief. Possibly this is symbolic of some of our troubles in psychiatry. We ran into both technical and communication difficulties, and we hope you will forgive us for that.

PROCEEDINGS

of

THE NOVA SCOTIA PSYCHIATRIC EXAMINATION

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SUBMISSION OF

NEW BRUNSWICK PSYCHIATRIC ASSOCIATION

PREAMBLE

The brief which follows relates to Mental Health Services in New Brunswick. It is assumed that statistical data concerning such service will already have been submitted to the Royal Commission from other sources. The New Brunswick Psychiatric Association, therefore, confines its submission largely to that part of the Royal Commission's inquiry which has to do with deficiencies in existing services and methods of improving them. Some of the ensuing remarks, however, also touch on problems of medical manpower in this field of psychiatry.

This brief is presented in three parts:

A. Deficiencies of existing services.

B. Explanatory notes.

C. Principles for future planning.

A. The New Brunswick Psychiatric Association wishes to apprise the Royal Commission of its belief that the mental helath needs of the people of this province are poorly served. The Association's dissatisfaction with existing psychiatric services is based on the following observations:

1. Of the two mental hospitals in the province, one is grossly overcrowded. The standard of patient care in these hospitals is, although not necessarily inferior to that prevailing in many state

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A. The New Brunswick Psychiatric Association wishes to apprise the Royal Commission of its belief that the mental health needs of the people of this province are poorly served. The Association's dissatisfaction with existing psychiatric services is based on the following observations:

1. Of the two mental hospitals in the province, one is grossly overcrowded. The standard of patient care in these hospitals is, although not

and provincial hospitals in North America, greatly below that accorded to physically ill patients in general hospitals. Neither of the mental hospitals has an out-patient department. Too few nurses are employed, and the patients are looked after by attendants, many of whom are poorly educated and have little training for the duties they are required to perform. The professional opportunities in these hospitals have been unattractive in comparison with those available elsewhere, and a measure of this unattractiveness is the hospitals' inability to attract Canadian medical graduates, who at the present ime comprise less than 25 per cent of the staff of the two hospitals. The hospitals have only limited and tentative approval for the training of psychiatric residents. In short, were the principles used for this assessment of general hospitals to be applied to mental hospitals, it is doubtful if either of the New Brunswick mental hospitals would come anywhere near to gaining official accreditation.

2. Mental Health Clinics are too few in number, and two of the existing four are functioning in a purely nominal fashion. Here again the main problem seems to be the inability to secure the services of properly trained psychiatrists.

3. There are no in-patient services for mentally retarded or emotionally disturbed children.

4. Little use is made of psychiatric services by the courts, and psychiatric services to correctional institutions are of a minimal kind.

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Little use is made of psychiatric services by the courts, and psychiatric services to correctional institutions are of a minimal kind.

5. Only two general hospitals in the province have psychiatric wards. Neither of these provides out-patient services.

6. The various psychiatric services of which mention has been made above are poorly integrated one with the other. The extent to which they are supplemented by the private practices of psychiatry is but slight. (There are in the province three psychiatrists actively engaged in private practice).

7. Only in Saint John and Campbellton, and to a limited extent in Moncton can a psychiatric patient obtain in-patient treatment near to his home, and subsequently have his case followed by psychiatrists who are familiar with his problems. Not only is the important principle of continuity of care violated by the concentration of in-patient facilities in these areas, but in large sections of the province the possibility of after care of any kind is quite remote.

B. In delivering itself of this criticism of existing psychiatric service, the New Brunswick Psychiatric Association feels bound to offer some explanation of the shortcomings to which attention has been drawn.

In the first place it needs to be made clear that, since the services provided by the three private practitioners and one psychiatrist employed by DVA are meeting the needs of only a small minority of the population, our dissatisfaction is in the main with the psychiatric services provided by the Provincial Government. There are no political connotations to this statement, as experience with different governments

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IX. In delivering itself of this criticism of existing psychiatric service, the Mental Hygiene Association feels bound to offer some explanation of the shortcomings to which attention has been drawn.

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has led us to the belief that the fault lies with the system rather than the political persuasions of those who operate it. An attempt will therefore be made to show why the existing methods of mental health administration fail to meet the needs of the mentally ill in an adequate fashion.

At this juncture it may be appropriate to observe that psychiatry is a young specialty, the scientific bases of which are insecure in comparison with those of other branches of medicine, and the techniques of which have all the imperfections of the empirical. Inasmuch as this is the case, the needs of the mentally ill are bound to be met inadequately, in our present state of knowledge, under any system. Nevertheless, were these limited technical resources used to the full, much more could be done for the psychiatrically ill in this province than is being done at the present time. Our main criticism, indeed, of the present system of mental health administration is that it fails to take proper cognizance of recent trends in psychiatric practice. These trends, and the hostorical background to which they must be related, will now be briefly reviewed.

Patients who come to the attention of psychiatry may fall into one of the following categories:

1. Psychotics.
2. Mental defectives.
3. Psychoneurotics.
4. Those with psychosomatic disorders.
5. Those with personality disorders. (This

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Patients who come to the attention of psychiatry may fall into one of the following categories:

1. Psychotics.

2. [illegible]

3. [illegible]

4. [illegible]

5. Those with personality disorders. (This

category includes "psychopaths" and the great majority of addicts).

6. Geriatric patients with psychiatric problems.

The therapeutic zeal which charactierizes much of modern psychiatric thinking is a relatively new phenomenon. Prior to its advent, psychiatry had little to do with patients in the last four of the above categories. Psychoneurotic disorders and psychosomatic complaints remained in the province of general practitioners (albeit frequently not recognized as psychogenic illnesses), psychopaths made a nuisance of themselves in society or drifted into correctional institutions, and the mental afflictions of the aged were accepted as an inevitable consequence of senility. Traditionally, mental hospitals were for those in the first two categories, the insane and the defective. Originally the places set aside for the custodial care of those thus afflicted, wherein the inmates were protected from society and whereby society was protected from the inmates, were known as asylums. Only later, with increasing recognition of insanity as something akin to physical illness, did the asylums come to be known as hospitals. More recently yet came increasing recognition that the sphere of mental disorders was wider than lunacy and defect. Awareness of this (stimulated, perhaps, by the spate of "shell shock" cases from the First World War) led to a demand for early and preventice treatment. There ensued a burgeoning of "extramural" services - psychiatric wards in general hospitals,

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mental health clinics, child guidance clinics, day hospitals, and so forth. Whereas it was originally envisaged that such services, operating in the community in association with and in a manner comparable to general medical services, would be concerned mainly with the treatment of psychoneurotic and kindred disorders, it has been increasingly found that a great majority of psychotic conditions are equally amenable to treatment in extramural settings. It has been estimated that in Canada 40 per cent of psychiatric first admissions are to psychiatric beds in general hospitals, and were such general hospital facilities more widely available this figure would undoubtedly be much higher. Elsewhere it has been shown that the shift towards community treatment reduces the need for chronic psychiatric beds, and the actuarial implications of this are such that the British Ministry of Health is able to announce a policy of moving toward the virtual abolition of mental hospitals.

Mental hospitals on this continent have in general been slower to accept the challenge of the demand for therapy than were those in Europe. In consequence, instead of the new extramural services developing as natural outgrowths of existing hospitals, they developed independently. In doing so they, together with the private practice of psychiatry, attracted many of the best trained professional people away from the mental hospitals. In one way and another the latter were left in an unfortunate predicament, for the stigma of mental hospitals clung not only to patients but to

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staff. In contrast to the professional respectability associated with mental hospital work in Europe, doctors and nurses in North America mental hospitals remained second class professional citizens. To this day the idea is prevalent that mental hospitals are staffed by doctors who (to quote an eminent American psychiatrist) have succeeded in finding a useful function for themselves after failing in the practice of medicine. Meanwhile the mental hospitals were losing not only their best staff but, at the very moment when their administrators were making some concessions to the needs of therapeutic versus custodial psychiatry, they were losing their most treatable patients. Ironically enough the more widespread popularity of pshcyiatry added to their difficulties. It led to an increasing tendency to label as psychiatric a much wider range of human afflictions. The mental hospitals came under increasing pressure to admit psychopaths and the mentally infirm aged, categories of patients for whom their facilities are ill adapted and for whom, it is generally agreed, alternative provision should be made. In short, mental hospitals have found themselves ill equipped to do the job they should be doing, ill coordinated with other facilities in the same field, and saddled with the care of those whose disabilities have but a small psychiatric component and whose presence in the hospitals further impedes the effective treatment of the mentally ill.

The above account, abbreviated but not greatly distorted, delineates the anachronistic position of many

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mental hospitals, our own among them. As presently organized they constitute a cumbersome and relatively ineffective way of providing a psychiatric service; the service thus provided is far from comprehensive, and the supplementation of the hospitals by a few mental health clinics is of only small help; the whole administrative machinery of the hospitals is based on a concept of custodial care which is alien to all the tenets of good psychiatric practice; and this custodial care is not confined to the mentally ill but is extended to others whose problems are only marginally psychiatric. The question immediately arises, therefore, as to why this unsatisfactory state of affairs persists. We wish to suggest that the hospitals' failure to adapt to the needs of the situation is explicable in terms of the following factors:

1. Of overriding importance is the fact that the policy of the hospitals is not, in the final issue, determined by the psychiatrists. General hospitals have medical boards and staff committees, which work with the superintendent but not under his direction. Such professional self-governing bodies determine, among other things, standards of treatment and who shall or shall not be treated. It is inconceivable that a surgeon, for example, would be ordered by the directors of a hospital to admit and treat a patient. Mental hospitals, by contrast, have a medical hierarchy modelled on Civil Service lines. Whether or not he wishes to be so, the superintendent is forced into a position of autocracy. He

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is answerable to the Director of Mental Health Services, and he in turn to the Deputy Minister of Health. As a result of this system little that is of fundamental importance to the hospital is decided at the level of those most concerned with its operation. Decisions are made by the Deputy Minister, who is not himself a psychiatrist. These decisions, appropriate enough in the field of Public Health, are not always in the best interests of psychiatry.

2. The psychiatrists in the Mental Health Service are, by virtue of being Civil Servants, in a poor position to assert themselves. As they become more senior in the service they become more beholden to the government which employs them, and less able to take a firm stand on matters of principle. While having no objection to the remuneration of physicians by salary, we cannot emphasize too strongly our objection to making doctors civil servants. There is no surer way of lowering professional standards.

3. Necaise tjere jave neem mp gemerally agreed criteria whereby the standards of mental hospitals or mental services could be judged, it has been up to the individual superintendents and Directors of Mental Health Services to "sell" improved standards to their Deputy Ministers on their merits, and speaking with no authority but their own they have had a hard time in doing so.

4. The organization and policy of mental hospitals has been determined too much by expediency (often political expediency) and too little by the

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4. The organization and policy of mental hospitals has been determined too much by expediency (often political expediency) and too little by the

needs of the mentally ill. The importance of a mental hospital as a source of income and employment in the neighbourhood in which it is situated, its potentialities as an instrument of political patronage, and the demands of an often ill-informed public, are factors which have often been allowed to override the primary function of the hospital, namely the best possible treatment of patients.

C. With the foregoing considerations in mind the New Brunswick Psychiatric Association recommends that plans for future Mental Health Services in New Brunswick should incorporate the basis principles which, together with some of their implications, are enumerated below.

1. The standards of Mental Health Services should be established by an external authority. That is, the setting of standards should not be left in the hands of the authority concerned with financing such services. In this connection, we look with great favour on the intention of the Canadian Council of Hospital Accreditation to extend its activities to mental hospitals. We feel there should be some incentive, e.g. tje cpmdotopma; ½rpvosopm pf federal moneys, to a provincial government to meet the standards to be established by the Canadian Council od Hospital Accreditation.

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2. The mental health services of this province should be planned so that the majority of the mentally ill can be treated in or near the community-

in which they live. Such community treatment would require the development, in association with the existing mental health clinics, of in-patient psychiatric facilities in the local general hospitals, and considerable extension of their out-patient services. Several regional psychiatric facilities of this combined type (i.e. providing both in-patient and out-patient diagnostic, treatment and rehabilitation services) would be required for the province.

3. Inasmuch as the great majority of the mentally ill can be treated in the community and returned to their homes, the role of the mental hospitals is seen as one of diminishing importance. Just what their final role should be is a question that must remain for the time being unanswered. It is generally accepted that the widespread adoption of active psychiatric treatment in the manner suggested above will greatly reduce the mental hospitals' population of chronic cases, but it will be some years before there is general agreement about the number of patients who are likely to require continued in-patient care. We consider that the problem of the chronic psychiatric patient is part of the larger problem of the chronically ill in general, and we take note of the fact that this is a problem with which society as a whole is much concerned. While registering our own partiality for the proposals of McKeown, we feel that no system yet advocated can, in the present state of knowledge, provide the final answer. We simply propose, therefore (a) that no new

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mental hospitals should be built, and that present mental hospitals should not be expanded; and (b) that care of the chronic psychiatric patient should be provided in circumstances not inferior to those accorded to the chronically ill in other categories..

4. The role of the Mental Health Services in respect of the mentally defective, the criminally insane, and the mentally infirm aged needs to be more clearly defined. While this brief has been concerned primarily with the needs of the mentally ill, it is generally agreed that psychiatry has a part to play, often a major part, in the management of problems created by persons inf these three categories. Our contention is that these problems are never entirely psychiatric (for example, in the field of mental deficiency the chief requirements are for special educational facilities), and we therefore look with disfavour on the present "all or none" approach whereby psychiatry is either over-emphasized by putting such persons in the mental hospital, or under-emphasized by methods of disposal which neglect the potential contribution of psychiatric knowledge. Without digressing from our main theme by going into all the relevant arguments, we desire to express our agreement with those who propose separate institutions for the mentally defective, the aged, and certain types of anti-social persons. Such people are poorly served by the mental hospital, and require a different kind of care from that provided for the mentally ill.

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whatever the organizational framework, Mental Health Services are, in the final analysis, provided by people. A great deal could be done to raise the level of Mental Health Services by improving the circumstances and professional opportunities of the medical staff. As matters stand there is a premium on non-professional activities. There is more emphasis on being a good Civil Servant than on being a good doctor; and the greatest rewards, in terms of prestige and salary, go to those who abandon clinical work for administration. We see a great need to replace the present mental hospital hierarchy, in which clinicians are devalued, with a system comparable to that of general hospitals in which clinicians are given authority commensurate with their professional status. To treat physicians as technicians who must conform with Civil Service policies they have had no share in shaping, is bound to result in their demoralization, and makes for a poor Mental Health Service. Just how the stultifying effects of bureaucracy can be minimized while doctors are in fact civil servants, is hard to see. We consider that the establishment of medical staff committees, and the employment of part-time consultants who are remunerated on a sessional basis, would go far towards remedying the apathy that all too commonly afflicts doctors enjoying the dubious benefits of full-time Civil Service employment.

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COMMISSIONER BALTZAN: I appreciate very much this presentation, its briefness and its direct statements. I have no specific questions to ask.

COMMISSIONER McCUTCHEON: What would be involved -- I take it you have said that the two mental hospitals now existing fall bar below the accreditation standards of the Canadian Hospital Association: have you any idea what would be involved in bringing them up to those standards, both in physical equipment and staff?

DR. BLACK: I think the answer to that is that as yet the standards as far as we are aware have not been officially approved and passed by the Canadian Hospital Association. They have been under discussion, but we haven't seen any final copy of them.

COMMISSIONER McCUTCHEON: While it is under consideration, they don't attempt to give accreditation to mental hospitals?

DR. BLACK: There has been no attempt. It has been relatively recently organized. Prior to this accreditation of the hospitals was done by the American body.

COMMISSIONER McCUTCHEON: I take it these hospitals don't come up to the American standards?

DR. BLACK: The American standards have not been applied to all of them. They were applied to the hospital in Lancaster about ten years ago. They have not been applied since that time, and in any case, psychiatrists in Canada generally have felt that the American standards were rather saddly lacking from our

COMMISSIONER BAITZAN: I appreciate

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American standards were rather sadly lacking from our

point of view too.

COMMISSIONER McCUTCHEON: If you were to obtain the movement out of these hospitals that you are visualizing, do you visualize psychiatric wards in general hospitals?

DR. BLACK: That would be one thing.

COMMISSIONER McCUTCHEON: And out-patient psychiatric clinics attached to general hospitals?

DR. BLACK: Yes.

COMMISSIONER McCUTCHEON: How many psychiatrists would you need in the province to carry on efficiently on that basis assuming you reduced your population of mental hospitals to the chronic, and let us say, the incurables and special classes you refer to?

DR. FORSYTH: The problem has been studied so little, there have been no statistics on the number of patients requiring treatment, that the number required to do a good job just cannot be estimated at present. Even to see the people that are presented now would take at least twice as many as we have. That is not even starting to do a job.

THE CHAIRMAN: Do you envisage the eventual closing of these present mental hospitals?

DR. FORSYTH: No, sir, not for a generation at least. There are many problems that obviously will have to stay until they pass on.

THE CHAIRMAN: Those are the chronic incurable people, I suppose?

DR. FORSYTH: Yes, and a good percentage of them are really physically incapacitated,

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and this is one of the points we make, that in the chronically ill the problems of the chronically mental ill and chronically physically ill approach one another.

THE CHAIRMAN: What happens in the Province of New Brunswick where a person -- and you speak of the criminally insane, but before they reach that condition, where a person is suspected of having commited a crime and there is a question as to whether he is sane or insane, that is, fit or unfit to stand trial, and he is remanded by the court for examination, where does he go for that examination?

DR. BLACK: To the mental hospital for thirty days observation and report.

THE CHAIRMAN: If he should be found not guilty but insane following a trial, he goes to the mental hospital again?

DR. BLACK: Yes, on a lieutenant-governor's warrant.

THE CHAIRMAN: And if he is found unfit to stand trial, again he goes under the lieutenant-governor's warrant to the mental hospital?

DR. BLACK: To the mental hospital, yes.

THE CHAIRMAN: So, to a degree, you must have places where there will be custodial as well as remedial care?

DR. BLACK: Yes.

COMMISSIONER McCUTCHEON: In the Province of New Brunswick, as I understand it, the province takes care of a substantial portion of the cost

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THE CHAIRMAN: So, to a degree, you must have places where there will be custodial as well as remedial care?

COMMISSIONER MOUNTCHESTON: In the Province of New Brunswick, as I understand it, the province takes care of a substantial portion of the cost

of hospitalization in mental hospitals, but patients are required to pay something; is that correct?

DR. FORSYTH: Yes.

COMMISSIONER McCUTCHEON: What is your association's views as to the differentiation between mental illness and organic illness under the hospitalization insurance scheme?

DR. FORSYTH: We feel any attempt to differentiate the two is most undesirable, that as long as this separation of the two types of illness persists, that this will continue to cause increasing difficulties in staffing and in getting the patients well.

COMMISSIONER McCUTCHEON: You are saying, in other words, that if there is going to be a plan to take care of illness that it should cover all illness?

DR. FORSYTH: Correct.

COMMISSIONER McCUTCHEON: Let me ask one other question: are there, in fact, any psychiatric patients treated in general hospitals in New Brunswick today?

DR. FORSYTH: We have three hospitals with psychiatric units: in Moncton, and the D.V.A. hospital in St. John, and the general hospital in St. John.

COMMISSIONER McCUTCHEON: Leaving out the D.V.A., you have general hospitals that come under the insurance scheme, and is a person going into these psychiatric units covered by the insurance scheme?

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DR. ROBERTS: Yes.

COMMISSIONER MACDONALD: What is your association's views as to the differentiation between mental illness and organic illness under the [illegible]

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COMMISSIONER MACDONALD: Let me ask one other question: are there, in fact, any psychiatric patients treated in general hospitals in

hospitals with psychiatric units: in Moncton, and the D.V.A. hospital in St. John, and the general hospital

but the D.V.A., you have general hospitals that come under the insurance scheme, and is a person going into these psychiatric units covered by the insurance scheme?

DR. FORSYTH: Yes.

COMMISSIONER McCUTCHEON: So the real difficulty is that if he gets into the general hospital he is covered, and if he goes into the mental institution ----

DR. FORSYTH: He is not covered.

COMMISSIONER BALTZAN: May I put one question, and I hope it is a fair one. However, it is true, and you have substantiated what we have heard before, that there is a decline in the size and the occupancy of mental hospitals, and one wonders what is the main contributing factor. Is the decline a very noticeable one to the extent you could even say that ultimately you want these hospitals entirely removed and there will be no use for them? Is it because there is a greater availability of personnel, psychiatrict personnel, or what part has the introduction of the new drugs,especially the ataraxics and analeptics, and the others currently used, contributed to this new revolutionary phase in this new psychiatric treatment of patients? My question is, is it because we have more psychiatric personnel then we had a dozen years ago, or is it because we have so much more in the way of medication for a good many of these remedial conditions?

DR. HANDFORTH: I think there are multiple factors involved here. The new drugs have undoubtedly played a part, but of themselves I would not say they were the major factor. I think perhaps -- and I don't know to which of the two factors I am going to mention I would give prior place -- but there are two

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DR. SHEPHERD: [illegible]

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DR. HAMPORTH: I think there are multiple factors involved here. The new drugs have undoubtedly played a part, but of these I would say they were the major factor. I think perhaps -- but I don't know to which of the two factors I am going to mention I would give prior place -- but there are two

that stand out in my mind: one is the increased trend towards community treatment, so that an individual who would have previously gone to a mental hospital does now in some areas have the opportunity to see a psychiatrist in his private office and perhaps be admitted to a psychiatric bed in a general hospital, and those of us working in these communities have had experience that we have had to commit to the mental hospital a very small proportion of our patients. Even though suffering from the so-called psychotic illnesses they do seem to be able to get through these episodes in the community and sooner or later return to some kind of productive life albeit perhaps in a sheltered setting. I am afraid I can't offer you any statistical evidence of this. I think it is the kind of thing that is being compiled at the moment but has not reached the publication stage. We all have the impression that comparable patients admitted to the mental hospital are lingering on there and are not getting out into society. In saying this we are not criticising the medical techniques used in the mental hospitals. The psychiatrists there, I am sure, are just as skillful, and they have access to the same drugs and physical forms of treatment and we feel it is something to do with the patient's physical environment in the course of his illness. We don't know quite why or how this works, but we do know that the chances of the psychotic patient being discharged become progressively less the longer he stays in hospital, and that being a long term patient in hospital increases his chances of staying there for a great many

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become progressively less the longer he stays in hospital, and that being a long term patient in hospital increases his chances of staying there for a great many

years, if not for life.

This, then, is a partial answer to your problem that the increase in treatment of psychiatric cases in the community is undoubtedly contributing to cutting down the population of mental hospitals.

However, I think there is another factor and it is this: that this community treatment by psychiatrists working outside mental hospitals would not be possible were there not a concomitant increasing tolerance on the part of society for its mentally afflicted members. I think this is part of a general trend; I suppose we would call it a humanitarian trend, that is taking place in our present age. We don't feel that this is something new, but rather a return to a more humanitarian outlook than existed prior to the nineteenth century. In the nineteenth century, which was the heyday of large mental hospitals, there was much emphasis on productivity,and an individual who was not being productive tended to be put on the shelf and locked up, whereas people now seem to be more tolerant of the mentally ill. So, it is the new attitude on the part of society, perhaps fostered by the activies of such organizations as the Canadian Mental Health Association, that enables us to treat patients in the community and keep them out of mental hospitals.

COMMISSIONER BALTZAN: I think your explanation throws a very interesting light on the prognosis and treatment of the psychotic individual. This approach does not depend entirely, then, on what

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I asked first -- whether it is the use of drugs or more psychiatrists, but that there is a bridge between those two?

DR. HANDFORTH: Yes.

COMMISSIONER BALTZAN: And the factors that you describe are of great assistance towards the treatment and better prognosis?

DR. HANDFORTH: That is correct, sir.

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THE CHAIRMAN: Dr. Forsyth, I am paraphrasing the last paragraph on page 9 in which there is reference to the status of the psychiatrist as a civil servant, and it is put that it is not a very good one, if I may put it mildly. Do you visualize the operation of hospitals as they now exist being possible without full-time, doctors being employed full-time?

DR. FORSYTH: Yes. We have discussed this among ourselves at great length, and we were not able to come to any decision whether this was really desirable. We feel the important separation is between the civil service and the hospital. The hospital organization should be for the benefit of the patients, whereas the whole attitude, tradition, everything else about the civil service is to protect the organization.

THE CHAIRMAN: May I put it this way. Is your professional psychiatrist on the staff of the hospital regarded as a civil servant or as an independent consultant, paid by the state?

DR. FORSYTH: His status is as a civil servant.

THE CHAIRMAN: Is there any form of oath or anything of that kind that he takes with other civil servants?

DR. FORSYTH: Precisely the same.

DR. BLACK: I have taken an oath as a civil servant, I guess. I should think - I can only guess at this - I would guess that the official answer is that we are not regarded as civil servants, but our conditions of service are precisely the same as other civil servants,

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promotion and so on.

THE CHAIRMAN: Pension, retirement?

DR. BLACK: Yes, and I presume one is a civil servant.

THE CHAIRMAN: Thank you very much, gentlemen.

The next submission will be from the New Brunswick Dental Society.

SUBMISSION OF THE NEW BRUNSWICK DENTAL SOCIETY

Appearances: Dr. A.J. Coughlan
Dr. R.F. Sansom
Dr. H.F. Bonnell
Dr. J.F. Edgecombe

--- EXHIBIT NO. 40: Submission of The New Brunswick Dental Society.

DR. EDGECOMBE: Mr. Chairman, members of the Commission, ladies and gentlemen, perhaps I should start by introducing the dentists here. On my extreme right is Dr. Coughlan. He is a past-President of the Canadian Dental Association and also honorary life member of the New Brunswick Dental Association. Next is our Secretary-Registrar, Dr. Sansom of SaintJohn and Dr. Hugh Bonnell of SaintJohn, and I am the Chairman of the Committee that produced the report, and that is the reason why I take the opportunity of reading this.

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SUMMARY OF THE REPORT

1. Preventive dentistry: This has the greatest possibility of raising dental health standards at the lowest cost. This includes preventive dentistry by the dentist for the patient, fluoridation of communal water supplies, and public education by radio, press, television, lectures, etc. Money to subsidize this should be forthcoming from governments and municipalities.

2. Manpower: To implement any treatment plan for the general public more dentists are needed. To obtain this, subsidization for dental students is necessary, in addition to more dental faculties at Universities across Canada.

3. Research: Dental research holds the key to open unknown ways of improving dental health standards of the public. Governments should spend more on this neglected branch of dentistry.

4. Dental Assistants: Group practice would allow more assistants to be utilized. Hospitals should have one or more dentists complete with technicians and staff, subsidized by the Government, to make dentures for the low income and welfare groups.

5. Hospital Dental Service: Subsidized dental clinics should be established in larger hospitals for both in-patients and out-patients. At present, the New Brunswick Hospitalization Act prevents dentists from admitting or discharging patients suffering from infection of a dental origin or injuries to dental structures.

6. Dentistry for children: This should have a top priority if and when any Government or compulsory

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5. Hospital Dental Services: Ambulatory dental clinics should be established in larger hospitals for both in-patients and out-patients. At present, the New Brunswick Hospitalization act prevents hospitals from admitting or discharging patients suffering from infections of a dental origin or injuries to dental structures.

6. Dentistry for children: This should be a top priority if and when any Government or municipal

pre-payment scheme is contemplated.

7. Dentistry may be divided under two classes for purposes of discussion - Preventive Dentistry and Treatment Dentistry. Of the two, the first is probably the most important if we were able to implement it to everyone. The second is costly but today very important from a health standpoint. Good dentistry, it is conceded, is most important to health. A statement made by Sir William Osler, "the father of modern medicine", is one with which we should ever be cognizant and mindful. He states, to quote, "There is no one single thing in preventive medicine that equals in importance mouth hygiene and the preservation of teeth".

8. It is important that two items of information be made available to you at once so as to better understand the problems which confront us.

9. The first is that our population in New Brunswick numbers about six hundred thousand and that the number of dentists practising for the public at present is about one hundred and fifteen.

10. Assuming that about half our population was interested in or of an age requiring immediate dental treatment, you can deduce the physical impossibility of our personnel to cope with this situation.

11. Three means are at our disposal to help reduce the amount of dental service and lower the incidence of tooth decay in our population. The first is preventive dentistry as practised in dental offices such as talks on diet, tooth brush drill, topical fluoridation applications on children's teeth and periodical dental

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examinations.

12. The second point, and a very important one, is Fluoridation of Communal Water Supply. This is not costly, amounting only to a few cents per person per year. The addition of Sodium Fluoride to the water supply bringing it up to one part per million has proven beyond the shadow of doubt to be an aid in reducing tooth decay by strengthening or hardening the tooth structure. There have been no proven deleterious effects. Some 45,000,000 people in America are receiving this now, yet the relationship of fluoride in the water supply to tooth decay was only discovered in 1940. In this province we have been thwarted by a decision of the Supreme Court of New Brunswick which ruled that our Health Act does not permit the addition of chemicals to our water supplies other than chemicals of a purifying nature. Sodium Fluoride, not being in this category, cannot be introduced until our Provincial Health Act has been amended. We hope to have this matter corrected and to be able to give the people of this province, particularly the children, the benefits of this great discovery.

13. Education of the general public in matters pertaining to their dental welfare should be an integral part of the duties of our profession. With such mediums as radio, television, the press, small pamphlets, etc., patients should be told the need for mouth hygiene and care of the teeth. We recommend that every effort be made to carry out a program of these three measures for the benefit of the people in all Communities in New Brunswick and the alleviation of the tremendous backlog of work

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which falls on the shoulders of so few.

14. Research: This is one of the most important aspects of dentistry. Government assistance to have more research in dental schools with grants paying the costs of this research would be of inestimable value to the people of Canada. Discoveries such as fluoridation were only possible with extensive research facilities.

15. Man Power: We have never been so fortunate with the facilities to teach dentistry than at the present time. We have new dental buildings in all six dental faculties at the six universities. These have very up-to-date equipment and in addition all have excellent teaching staffs. The ratio of dentists to population has been worsening each year. The dentists have had recruitment campaigns, had pamphlets printed, and completed various promotional schemes to solicit more students. If this ratio of dentists to population is to be improved, student subsidization is necessary to attract more eligible students. Scholarships, financial grants, and direct subsidization on condition that the students serve the province for a period of time after graduation would boost the number taking dentistry.

16. Dental Assistants: Most dentists have one assistant in their offices, call her a nurse, secretary, assistant, or office girl. If a dentist employs two assistants it improves his efficiency a great deal but it also increases his overhead. If he is away from the office because of sickness or even taking holidays, this overhead must be paid. Although dental hygienists are permitted in New Brunswick legally, there are none employed in dental

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offices mainly for this reason. Technicians used to be employed in dental offices but practically all technicians now have their own laboratories. There are about thirty technicians in New Brunswick which makes a ratio of approximately one technician to four dentists. This has been very practical. However, costs have been going up and technicians have been organizing and obtaining provincial charters. They work shorter hours for more pay. There has been a trend recently, for technicians to work directly for the public. This has led to ill-feeling between dentists and technicians and between the ethical technicians and the illegal ones. If accredited hospitals would establish dental clinics subsidized to a degree then this would make an ideal place to make dentures for the lower income and welfare groups. These dentures should be at a low fee and in volume. This would create understanding with the public, and would also stop much of the illegal denture service.

17. Hospital Dental Services: There are presently about eight hospitals in the province with accredited bed capacity of 100 or more.

18. They are reasonably strategically located, but only one, the Saint John General Hospital, offers free out-patient dental facilities. This is limited to extractions under local and general anaesthesia and minor maxillo facial injuries.

19. This Hospital has four local practitioners as staff members, who render such treatment as a public service.

20. The mental, tuberculosis and veterans'

[illegible]

In dental offices but [illegible]

[illegible]

technicians in New Brunswick which [illegible]
mately one technician to four dentists. [illegible]

technicians have been organizing and obtaining [illegible]

for the public. This has led to ill-feeling between
dentists and technicians and between the ethical [illegible]
and the illegal ones. If accredited hospitals would
establish dental clinics subsidized to a degree they [illegible]
would make an ideal place to make dentures for the [illegible]
income and welfare groups. These [illegible]
low fee and in volume. This would create goodwill [illegible]
with the public, and would also stop much of the illegal
denture service.

[illegible] about eight hospitals in the [illegible]
[illegible] bed capacity of 100 or more.

18. They are reasonably [illegible]
[illegible], but only one, the Saint John General [illegible]
[illegible] free out-patient dental facilities. [illegible]
[illegible] extractions under local and general anesthesia [illegible]

19. This hospital has four local [illegible]
[illegible] as staff members, who [illegible]
[illegible] service.

20. The mental, tuberculosis and [illegible]

hospitals in the province appear to have a satisfactory service, where either full, or part-time dental clinics have been established.

21. Establishment of dental clinics augmented by dental interneships in the larger centre public hospitals would no doubt render invaluable dental health service to both indoor and outdoor patients.

22. Under the present N.B. Hospitalization Act it would seem that discrimination against the dentist exists, in that a hospital staff dentist or any registered dentist cannot admit or discharge patients suffering from infections of a dental origin, or injuries to dental structures.

23. This would appear to be contrary to any general health service, of which dentistry is a recognized integral part. The Welfare Groups: Any family unfortunate enough to be included in one of the welfare groups will of necessity have to limit their dental treatment. The longer treatment is delayed the more expensive the treatment will be and the least satisfactory the final result.

24. The welfare groups may be roughly subdivided into two sections - those more or less permanently in need of assistance and those requiring help for a limited time only. In the case of the first section it can easily be seen that the best result would be obtained by starting dental treatment early. The latter section who require assistance for a limited time only may have their general physical recovery delayed for some time due to their dental condition. In many cases it would be cheaper

[illegible] in the [illegible] [illegible] [illegible] more often assistance.

21. Establishment of dental clinics augmented by dental internships in the larger centres [illegible] health service to both [illegible]

22. Under the present N.H. Hospitalization Act it would seem that discrimination against the dentist [illegible] dentist cannot admit or discharge patients suffering from [illegible] [illegible].

23. This would appear to be contrary to any general health service, of which dentistry is a recognized integral part. The welfare branch and family [illegible] unfortunate enough to be included in one of the welfare groups will of necessity have to limit their dental treatment. The longer treatment is delayed the more expensive the treatment will be and the least satisfactory the final [illegible].

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to give complete dental treatment in order to hasten rehabilitation and removal from the welfare lists.

25. Children in the welfare groups may have their dental treatment postponed until permanent damage has been done. If these children received treatment as long as they were attending school then they would have teeth worthwhile taking care of when they leave school and are able to look after their own needs.

26. RECOMMENDATIONS: Dental treatment should be provided at public expense for both adults and children of the welfare groups.

27. Dentistry for Children: In any dental health plan, children should receive a top priority for treatment. They are the coming generation and need all the assistance we are able to provide. Over one third of the population of New Brunswick are children under 19. If a government compulsory pre-payment dental health plan is implemented, then, instead of introducing this to all the children, it should start with ages three to six the first year, then three to seven the next year, and so on, until all the school children are covered. This of necessity would have to be augmented each year with more dentists. None of our dental colleges are up to capacity and some inducement must be made to attract more students to keep this plan operating.

APPENDIX "A"

NUMBER OF DENTISTS IN NEW BRUNSWICK (1)

1911 - 1941

1911	91
1921	112

25. Children in the welfare groups may [illegible] damage has been done. If these children received treatment as long as they were attending school then they would have teeth worthwhile taking care of when they leave school and are able to look after their own needs.

26. RECOMMENDATIONS: Dental treatment should be provided at public expense for both adults and children of the province.

27. Priority for Children: In any dental health plan, children should receive a top priority for treatment. They are the coming generation and need all [illegible]

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APPENDIX "A"

NUMBER OF DENTISTS IN NEW BRUNSWICK (1)

1941 - 1946

1931	124
1941	118 (2)

(1) Source: Census of Canada 1911, 1921, 1931, 1941.

(2) Includes 17 dentists on active service.

NUMBER OF DENTISTS IN NEW BRUNSWICK

Source: C.D.A. Statistical Data as compiled annually from submission from Provincial Registrars (as of January 1st)

Year	Civilian	Military
1943	71	23
44	75	23
45	89	25
46	91	14
47	110	4
48	108	
49	112	
50	105	
51	106	
52	110	
53	113	
54	116	
55	119	
56	122	
57	125	
58	125	
59	124	
60	114	
61	120	

Year	Civilian	Military
1943	71	22
[illegible]	[illegible]	[illegible]
45	89	09
[illegible]	[illegible]	[illegible]
47	110	[illegible]
48	108	
49	118	
50	105	
51	106	
[illegible]	[illegible]	
53	113	
54	116	
[illegible]	[illegible]	
56	122	
[illegible]	125	
58	125	
59	124	
60	114	
61	120	
1931		
1941	119 (2)	

Source: U.D.A. Statistical Data as compiled annually

(as of January 1st)

APPENDIX "B"

DENTISTS OF NEW BRUNSWICK BY TOWNS AND CITIES

Compiled from Canadian Dental Association Directory

Andover	1
Bathurst	5
Buctouche	1
Bristol	1
Campbellton	3
Caraquet	1
Centreville	1
Chatham	3
Dalhousie	2
East Florenceville	1
Edmundston	7
Fredericton	12
Grand Falls	3
Hampton	1
Minto	1
Moncton	18
Newcastle	2
Perth	1
Petitcodiac	1
Rexton	1
Richibucto	1
Sackville	2
Saint John	33
Shediac	3
St. George	1
St. Leonard	1
St. Stephen	3

Compiled from Canadian Dental Association Directory

Andover	1
Bathurst	5
[illegible]	
Bristol	1
Campbellton	3
[illegible]	
Centreville	1
Chatham	
[illegible]	
[illegible]	
Edmundston	7
Fredericton	12
[illegible]	
Hampton	1
[illegible]	
Moncton	14
[illegible]	
Perth	1
Petitcodiac	1
[illegible]	
Richibucto	1
Sackville	2
Saint John	34
Shediac	3
St. George	1
St. [illegible]	
St. Stephen	3

St. Quentin	1
Sussex	3
Tracadie	1
Woodstock	4
	119

APPENDIX "C"

RATIO OF POPULATION TO DENTISTS

Compiled by Department of Health.

County	Population 1959	Dentists	Population Per Dentist
Albert	11,520	Nil	N/A
Carleton	24,271	5	4,854
Charlotte	25,303	5	5,060
Gloucester	69,319	8	8,665
Kent	29,208	2	14,604
Kings	25,188	3	8,396
Madawaska	39,964	8	5,000
Northumberland	50,954	5	10,190
Queens	13,350	Nil	N/A
Restigouche	42,968	7	6,138
Saint John	85,579	31	2,760
Sunbury	11,795	2	5,897
Victoria	20,539	5	4,108
Westmorland	90,828	26	3,500
York	49,880	12	4,156
Total:	590,666	119	

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Kent	29,208	2	14,604
Kings	25,188	3	8,396
Madawaska	39,964	8	5,000
Northumberland	50,994	5	10,120
Queens	13,350	Nil	N/A
[illegible]	[illegible]	1	[illegible]
Saint John	85,579	31	2,760
Sunbury	11,795	2	5,897
Victoria	20,539	5	4,108
Westmorland	90,828	26	3,500
York	49,880	12	4,156
Total	[illegible]	141	

APPENDIX "D"

ESTIMATED POPULATION BY AGE - 1959

in '000s

Compiled by Department of Health

0 - 4	79
5 - 9	75
10 - 14	66
15 - 19	53
20 - 24	41
25 - 34	70.3
35 - 44	68
45 - 54	54.3
55 - 64	38
65 - 69	15.4
70 +	30
Total:	590

APPENDIX "D"

[illegible] POPULATION BY AGE - 1[illegible]

in '000s

[illegible]	
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
Total:	[illegible]

DR. EDGECOMBE: I might also remark that this brief was produced in very much of a hurry. We had the annual meeting of the New Brunswick Dental Society early in October and we got your Terms of Reference not too far ahead of that, and this brief was produced not knowing exactly what was required.

THE CHAIRMAN: Dr. Edgecombe, I would like to make it quite clear that if you should have any further submission to make, should the New Brunswick Dental Society have anything further to offer to the Commission, please do not hesitate to do so; it can always be sent to the Secretary and it will receive the consideration of the Commission, rather than there should be any want of consideration because of the time element.

DR. EDGECOMBE: Thank you.

THE CHAIRMAN: Now, you speak of fluoridation of the communal water supply. I take it is the attitude of the New Brunswick Dental Society that that should be done?

DR. EDGECOMBE: Very much so, yes, sir.

THE CHAIRMAN: What is the situation in New Brunswick? Are there any places where it is done?

DR. EDGECOMBE: No, none at all. There is an Act in the Province which states that chemicals may be added to the water supply, and the interpretation given by three Supreme Court judges was that that was only for purification purposes, and therefore unless the Act is changed, we cannot add chemicals to our water supply anywhere except for that purpose. And every year we put up a letter to the Government asking them to change the Act, but to date it

early in October and we got your Terms of Reference not too far ahead of that, and this brief was produced not knowing exactly what was required.

THE CHAIRMAN: Dr. Edgecombe, I would like

submission to make, should the New Brunswick Dental

the Secretary and it will receive the consideration of the

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has never been done. In the City of SaintJohn, I think at least five or six years ago, we had a plebiscite on fluoridation, and the majority of people voted in favour of it, but we can't implement it until the Act is changed.

THE CHAIRMAN: As long as this judgment stands?

DR. EDGECOMBE: Yes.

THE CHAIRMAN: Is that of the Supreme Court of Canada?

DR. EDGECOMBE: The Supreme Court of New Brunswick. There were three judges. I think there was one minority judgment of one of the judges.

THE CHAIRMAN: The case was not taken to the Supreme Court of Canada?

DR. EDGECOMBE: No.

DR. COUGHLAN: It was a decision given by Supreme Court Judge John McNair, and in order to have fluoridation in the Province the Act would have to be amended because of the fact that he stated nothing could be added to the water supply of New Brunswick except as a puritive agent. Therefore if we wish to go ahead with that we have to have the Act amended, and it has never been brought up.

THE CHAIRMAN: And that is a matter of policy of the Provincial Government?

DR. COUGHLAN: That is right.

THE CHAIRMAN: In reference to dentistry for children, have you in New Brunswick a program of school dentists?

DR. BONNELL: I could answer for the City of

of it, but we can't implement it until the Act is changed.

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THE CHAIRMAN: The case was not taken to the Supreme Court of Canada?

DR. EDGECOMBE: No.

DR. COUGHLAN: It was a decision given by Supreme Court Judge John McNair, and in order to have fluoridation in the province, the Legislature would have to amend Section 4 of the Act that fluoride would be added to the water supply of New Brunswick except as a qualified exception. [illegible] that we have to have the Act amended, and it has never been brought up.

THE CHAIRMAN: Are that is a matter of [illegible] of the Legislature?

DR. COUGHLAN: That is right.

THE CHAIRMAN: In reference to dentistry for children, have you, Mr. Tessmann, a [illegible] dentists?

DR. BONNELL: I could answer for the City of

Saint John and Moncton as well. The Board of Health of both those centres employs full-time dentists to run full-time clinics for schoolchildren. In Saint John, for instance, there are actually two full-time clinics in operation at the present time.

THE CHAIRMAN: How do the children find their way to the clinics?

DR. BONNELL: A lot is done by the public health centres and by the schoolteachers.

THE CHAIRMAN: Is this service free or is there a charge?

DR. BONNELL: It is free, for people who can't afford it.

THE CHAIRMAN: That is a different story. But is it available to all or to a select group?

DR. BONNELL: No, only to a group who are not able to afford it.

THE CHAIRMAN: How are they determined?

DR. BONNELL: Actually the Board itself tries to screen the applicants for this. There is a table - I can't give you the exact figures that were used, but I believe the figures were determined from figures supplied by the Federal Government on income and numbers of children. In other words, without giving figures, a certain income and a certain number of children in the family would automatically make him eligible for treatment, whereas possibly someone with the same income but one child would not be eligible.

THE CHAIRMAN: That is done by the Board of Health and not by the School Board?

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THE CHAIRMAN: That is done by the Board of

Health and not by the School Board?

DR. BONNELL: That is done by the Board of Health.

THE CHAIRMAN: Does it run through the whole elementary system?

DR. BONNELL: It is right from Grade 1 to Grade 12.

COMMISSIONER STRACHAN: Mr. Chairman, in that connection, where is the service rendered?

DR. BONNELL: There are two clinics. One is right in the building which houses the Board of Health, and that is in Saint John, and the other clinic is in a school in Lancaster, one of the schools. I said the City of Saint John. Actually it is the municipality.

COMMISSIONER STRACHAN: Does the Department of Public Health, the Government, render any assistance?

DR. BONNELL: Yes, they do. As a matter of fact, one of the dentists is paid completely by the Provincial Department of Health.

COMMISSIONER STRACHAN: One of the dentists. You mean one of those dentists operating in the clinics?

DR. BONNELL: Yes. Actually they are paid through the Board of Health, but the funds are made by the Provincial Department, and the other is financed by the municipality.

COMMISSIONER STRACHAN: Then in paragraph 5 of your summary you say: "Subsidized dental clinics should be established in larger hospitals for both in-patients and out-patients". Are there any dental clinics in any hospitals in the Province, and, if not, what effort has been made to establish them and what has been the result?

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COMMISSIONER STRACHAN: Then in paragraph 5 of your summary you say: "Subsidized dental clinics should be established in larger hospitals for both in-patients and out-patients". Are there any dental clinics in any hospitals in the Province, and, if not, what effort has been made to establish them and what has been the result?

DR. BONNELL: The first question - could I add a little bit to that?

COMMISSIONER STRACHAN: Yes.

DR. BONNELL: In addition to these full-time clinics in Saint John I believe there is a clinic in Moncton operated under a similar idea to the one in Saint John, and there are certain dentists throughout the Province on a part-time basis rendering treatment to schoolchildren, and that is financed by the Provincial Department of Health as well. That would be more in the outlying districts where it is felt that a full-time practitioner at the present time in the present circumstances, there would not be enough work for him, so it is done on a part-time basis, so many mornings a week.

In regard to your second question, to my knowledge the only hospital which offers out-patient or in-patient services to the public is the general hospital at Saint John, which has a staff of 4 dentists, and they do strictly extraction of teeth and minor oral surgery. That is gratis on the part of the dentist involved. The hospital does provide the facilities, which are very good.

COMMISSIONER STRACHAN: In the case of a matter of a fracture case coming to a dental office, how can he go about attending that patient in hospital?

DR. BONNELL: Well, it would be necessary for him to have one of his medical friends admit the patient to the hospital and then he can be called in to ---

COMMISSIONER STRACHAN: But he would be permitted to treat that patient in hospital?

DR. BONNELL: He would be permitted to work

DR. BONNELL: The first question - could I add a little bit to that?

COMMISSIONER STRACHAN: Yes.

DR. BONNELL: In addition to these full-time part-time basis rendering treatment to schoolchildren, at the present time in the present circumstances, there would not be enough work for him, so it is done on a part-time basis, so many mornings a week.

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DR. BONNELL: Well, it would be necessary patient to the hospital and then he can be called in to --

COMMISSIONER STRACHAN: But he would be permitted to treat that patient in hospital?

DR. BONNELL: He would be permitted to work

on him in the operating room, but really any drugs or anything of that sort of thing would have to be prescribed by the physician in the case.

COMMISSIONER STRACHAN: Is that true for the cases admitted for exodontia?

DR. BONNELL: Yes, the same thing. The physician can admit a patient to the out-patient service himself but not the in-patient, consequently most of the exodontia is done in the out-patient department.

COMMISSIONER STRACHAN: Another thing I would like to ask you. You were possibly here when the Government presented its brief this morning, and they made an estimate of the cost of dental service. Would you agree with the figure presented?

DR. EDGECOMBE: I would certainly not agree with that. My arithmetic is not very good, but I understood it was $5 per capita, and the average fee for one extraction in this Province is $4. I can't see that $5 per capita would cover any comprehensive scheme for dentistry in this Province. I have a book of some statistics which are probably available to you. It was produced by the Council of Education in the United States last year.

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The figures are this, that medical health care in the United States for the year previous was 20 billion dollars, and the dental health care was 2 billion, which is one-tenth, in other words. Now, that is just a rough idea, one-tenth of medical health care, but it will give some indication of the cost of comprehensive dental health care. But incidentally, the summary of that report, and I am sure you will have it, it was produced by money provided from the Kellogg Foundation, and it was subsidized again by the American Dental Association. It was a very comprehensive report.

COMMISSIONER STRACHAN: Speaking of subsidization of dental students as referred to in your brief. Has any effort been made to bring this about in the Province?

DR. EDGECOMBE: Not that I know of in the Province of New Brunswick. I do know that Newfoundland has a subsidization scheme, which I think has worked out very well. Practically every student they have subsidized has gone back to Newfoundland, and they are told where they will practise, and it is for a given time agreed in advance, and they are subsidized while they attend Dalhousie Dental School, and there is also the military scheme of subsidization, which is also, I think they have produced 257 to date, and a good percentage of them have gone back to private practice, and most of them have gone to the Province from which they came.

DR. COUGHLAN: By the way, the New Brunswick Government does give a grant to Dalhousie, not specifically for dental students, but to the University.

The figures are this, that medical health care in the United States for the year previous was 20 billion dollars, and the dental health care was 2 billion, which is one-tenth, in other words. Now, that is just a rough idea, one-tenth of medical health care, but it will give some indication of the cost of comprehensive dental [illegible] and I am sure you will have it, it was produced by money provided from the Kellogg Foundation, and it was subsidized again by the American Dental Association. It was [illegible]

COMMISSIONER STRACHAN: Speaking of subsidization of dental students as referred to in your brief, Has any effort been made to bring this about in the Province?

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DR. COUGHLAN: By the way, the New Brunswick government does give a grant to Dalhousie, not specifically [illegible]

DR.EDGECOMBE: I think that is for medical and dental students both. It is a yearly grant that they give.

THE CHAIRMAN: Yes, we were informed of that in the Dalhousie brief.

COMMISSIONER BALTZAN: I would like an explanation of wording here. "At present, the New Brunswick Hospitalization Act prevents dentists from admitting or discharging patients suffering from infections of a dental origin or injuries to dental structures". It is No. 5 on page 1. My question is, it prevents, and it is the Act that prevents?

DR. EDGECOMBE: The Act only allows that people who go into the hospital have their hospitalization paid for. In other words, at the present time the Government pays the hospitalization charge, and only the medical man can enter that patient who comes under that scheme.

COMMISSIONER BALTZAN: This latter portion is not written in the Act?

DR. EDGECOMBE: No, a medical man can take a patient in, and he can call in the dentist to treat that patient.

COMMISSIONER BALTZAN: But if that were as it is in many places under the aegis of the Hospital Board, there is no contravention in the Act, that is if dentists could arrange with the Hospital Boards that they form a department on their own, there is nothing in the Act to prevent that?

DR. BONNELL: No, even if the hospital was agreeable to a dentist admitting or discharging patients,

they get their funds from the Provincial Government under the Hospitalization Act, and the Hospitalization Act won't pay the bills for any patient that was admitted by a dentist.

COMMISSIONER BALTZAN: But if it is admitted by a physician, then the dentist does get paid. I am talking about the system of admission, and I want to know whether it is specifically stated in the Act that the dentist has no right and is prohibited?

DR. BONNELL: No, it does not say specifically that, but it does say that they must be admitted by a physician.

COMMISSIONER BALTZAN: And it says that in the Act?

DR. BONNELL: Yes.

COMMISSIONER BALTZAN: It specifically states that it must be admitted by way of a physician to the hospital?

DR. BONNELL: Yes.

COMMISSIONER BALTZAN: Would you tell me what has happened to, like on page 4, No. 18: "--- Saint John General Hospital offers free out-patient dental facilities. This is limited to extractions under local and general anaesthesia and minor maxillo facial injuries". But No. 19: "This hospital has four local practitioners as staff members, who render such treatment as a public service".

DR. BONNELL: Yes, that is right sir.

DR. EDGECOMBE: Dr. Bonnell is one of the four members.

pay the bills for any patient that was admitted by a dentist.

COMMISSIONER BAITZAN: But if it is admitted by a physician, then the dentist does get paid. I am talking about the system of admission, and I want to know whether it is specifically stated in the Act that the dentist has no right and is prohibited?

DR. BONNELL: No, it does not say specifically that, [illegible] does say that they must be [illegible] by a physician.

COMMISSIONER BAITZAN: And it says that in [illegible]

DR. BONNELL: Yes.

COMMISSIONER BAITZAN: It specifically [illegible] to [illegible]

DR. BONNELL: Yes.

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DR. BONNELL: Yes, that is right sir.

DR. EDGECOMBE: Dr. Bonnell is one of the [illegible]

COMMISSIONER BALTZAN: Do you mean there is a difference between someone who renders public health service as against private practitioners?

DR. BONNELL: No, I have no more, Dr. Sansom and I are both on the staff of the hospital, but we have no other privileges than the other dentists in the city.

THE CHAIRMAN: Is the distinction that you treat them as out-patients?

DR. BONNELL: Yes, we still cannot admit patients to the hospital. This is really a courtesy thing from the St. John General Hospital to us, in that we are treating patients who could not afford private treatment, but we have no right to prescribe or admit or discharge patients from the hospital.

COMMISSIONER BALTZAN: In other words, if it is a fault, it is a fault with the Act, not with the hospitals?

DR. BONNELL: Yes.

DR. SANSOM: There is a conflict between the hospitals and various Acts in the various Provinces. I believe in Ontario some patients can be admitted under the Hospital Insurance Act for extractions, or if necessary, for operative work, but there is a conflict with the accreditations board, and I believe now they are studying the problem. Their Act allows the dentist to admit the patient, but the hospital boards don't, so that is where the conflict is.

COMMISSIONER BALTZAN: That was the reason for my question as to who to pin this offence on.

DR. SANSOM: But in our Hospital Act in New

COMMISSIONER BAILTZAN: Do you mean there is [illegible] service as against private practitioners?

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COMMISSIONER BAILTZAN: That was the reason for my question as to who to pin this offence on.

DR. SANSOM: But in our Hospital Act in New

Brunswick there is no mention that it actually excludes dentistry in all forms, whereas in other Provinces it does, but even in the other Provinces there is still a conflict between the hospitals --

COMMISSIONER GIRARD: Dr. Bonnell, on page 5, No. 25, it states that children in the welfare group may have their dental treatment postponed until permanent damage has been done. Did I misunderstand the statement made a little earlier that public health nurses could refer needy children to clinics to get free dental treatment?

DR. BONNELL: No, that is correct, but it is only in two communities really in the Province. In the municipality of Saint John and in Moncton they can be referred to the school clinics, but it is a little more difficult in the outlying districts. Then of course, there is a tremendous backlog. I believe the two clinics in Saint John are not really able to render as much treatment as they would like to.

COMMISSIONER GIRARD: It is really only for the cities?

DR. BONNELL: Yes.

COMMISSIONER STRACHAN: I realize, Mr. Chairman, that this question might better have been put to a former organization but perhaps we can clarify it here. In the event that by the courtesy of a physician you have a fracture case admitted to the hospital and you, as a dentist, or any dentist, renders the treatment, can you receive a fee for that treatment under, for instance, the Maritime Hospital Services Association, or any other insurance?

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DR. BONNELL: No, we cannot. If a medical doctor, a physician treated the patient he could, but we cannot.

COMMISSIONER STRACHAN: Then would it be recognized if he did it in name and you actually did it?

DR. BONNELL: I am afraid I cannot answer that sir.

COMMISSIONER STRACHAN: But these insurance schemes recognize no dental treatment at all. I think that will suffice to make the point.

THE CHAIRMAN: It is an exclusion in the contract.

COMMISSIONER STRACHAN: What about the Workmen's Compensation Board?

DR. BONNELL: Yes, if a patient is referred by the Workmen's Compensation Board, a fracture case for instance, and the dentist renders the treatment we are paid directly by the Workmen's Compensation Board.

DR. EDGECOMBE: That cheque goes directly to the dentist. There was a time when it went to the patient and the dentist never saw it.

DR. MacDOUGALL: Mr. Chairman, may I correct one point with respect to the insurance payment. The statement they are making concerning a fractured jaw, for example, a patient admitted to hospital by a physician.

THE CHAIRMAN: I think we ought to put the facts correctly. I mean to say, so that you may answer them. All they are saying is that a dentist cannot admit anyone to a hospital for which they will be paid from funds in your Association.

COMMISSIONER STRACHAN: Then would it be recognized if he did it in name and you actually did it?

DR. BONNELL: I am afraid I cannot answer that.

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THE CHAIRMAN: It is an exclusion in the contract.

COMMISSIONER STRACHAN: Then about the doctor's compensation bill?

DR. BONNELL: Yes, if a patient is referred by the Workmen's Compensation Board, in instance, and the dentist renders the treatment we are paid directly by the Workmen's Compensation Board.

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THE CHAIRMAN: I think we ought to put the facts correctly. I mean to say, so that you may answer them. All they are saying is that a dentist cannot admit patients [illegible] in your Association.

DR. MacDOUGALL: Well, that is true.

THE CHAIRMAN: Yes, that is what they said.

DR. MacDOUGALL: Can you admit by the Workmen's Compensation for that?

DR. BONNELL: No, but we can be paid by the Workmen's Compensation.

DR. MacDOUGALL: And you can be paid by Blue Shield?

DR. BONNELL: Perhaps you are right, but it was my understanding that we couldn't.

THE CHAIRMAN: I read an exclusion in your contract, Mr. Doyle, unless you have changed it since you sent this exhibit in.

DR. MacDOUGALL: If a patient is referred by a doctor in the hospital for treatment of a fractured jaw by a dentist, the patient may be paid by the plan.

THE CHAIRMAN: That is what they have already said.

COMMISSIONER FIRESTONE: Mr. Chairman, my question is directed to Dr. Edgecombe. Is the New Brunswick Dental Association in favour of a prepaid comprehensive dental care program for the people of New Brunswick?

DR. EDGECOMBE: Well, we think that our members are far too few to attempt any such thing at the present time. We have a population, as you know, of around 600,000, and we have 115 dentists, and most of us are busy now, and add that on top, and I cannot see at the present time that we could get --- the same amount of butter for a lot more loaves would have to be spread around to far more people, but I do think that in the future,

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if they go on a comprehensive plan by going by steps and getting more dentists, that we would be in favour of it. I say that personally.

COMMISSIONER FIRESTONE: Are you in favour of the principle of a prepaid comprehensive dental care program for the Province of New Brunswick?

DR. COUGHLAN: We certainly would be in favour, but it is a physical impossibility at the present, and for some years to come, to accomplish that fact.

COMMISSIONER FIRESTONE: Would it be possible for the New Brunswick Dental Association, and I am directing the question again to you, Dr. Edgecombe, to advise the Royal Commission of what would be required in terms of numbers of dentists, and anything else to implement a program of prepaid dental care for the people of the Province of New Brunswick?

DR. EDGECOMBE: We have in this Province I think a ratio of dentists of one to 5,000. I think there is only one Province in Canada that is in a worse position, and that is Newfoundland, and that ratio of one to 5,000 is a very far off, shall we say -- in the United States they have a ratio of one to 2,000. The Canadian Army has one to 950. That ratio, one to 5,000, would have to be corrected considerably I would say before you could implement any plan, but I don't see why steps could not be taken over a period of time to do it by degrees, and in that way the end result would be met.

COMMISSIONER FIRESTONE: I take it from what you are saying, sir, that you, like the past Chairman of your Association, are in favour of the principle of a

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taken over a period of time to do it by degrees, and in that way the end result would be met.

COMMISSIONER FIRESTONE: I take it from what you are saying, sir, that you, like the past Chairman of your Association, are in favour of the principle of a

comprehensive prepaid dental care program, but you would like to see such a program implemented in the light of the resources that you will acquire to implement such a program, the resources involving men, equipment, lab facilities, hospital facilities, etc. Is that your position sir?

DR. EDGECOMBE: Yes.

COMMISSIONER FIRESTONE: Would it be possible to let the Commission know of how this desirable objective could be achieved in the Province of New Brunswick. What are your views as to the number of dentists required? How could those dentists be trained, persuaded to come here? How can you create the facilities and develop the people to provide such a program? You realize, Dr. Edgecombe, if this Commission is to make some recommendations, we must have the views of the people that are professionally in practice, and are competent to advise us, and we are coming to you to give us this advice. Would it be possible for your Association to give some thought to this matter, and let us know how such a desirable objective could be achieved in New Brunswick?

DR. EDGECOMBE: We would be very happy to do that.

COMMISSIONER FIRESTONE: And would you go further, and tell us in your opinion what such a program would cost for the Province of New Brunswick. You suggested earlier that the 5½ dollar figure approximately, given to us by the Department of Health, and you mentioned a 2 billion dollar figure being the dental bill of the American nation, but there are 185 million Americans, and that works out at roughly $11 per capita, or just about

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DR. EDGECOMBE: Yes.

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COMMISSIONER FIRESTONE: And would you go further, and tell us in your opinion what such a program would cost for the Province of New Brunswick. You suggested earlier that the $2½ dollar figure approximately given to us by the Department of Health, and you mentioned a 2 million dollar figure being the dental bill of the American nation, but there are 189 million Americans, and that works out at roughly $11 per capita, or just about

double the 5½ dollar figure suggested to us this morning. Are you suggesting that the dental cost per capita for the average citizen in New Brunswick would be equivalent to that for the average American?

DR. EDGECOMBE: No, I am certainly not.

COMMISSIONER FIRESTONE: And therefore that the figure would be somewhat lower than $11, and you might find the 5½ dollar figure submitted might not be far out, and therefore it would help the Commission if you could come to independent estimate, so that we can have an appreciation of what would be involved if such a program were to be proceeded with?

DR. EDGECOMBE: Yes.

COMMISSIONER FIRESTONE: Would you also care to offer us some advice as to how such a program should be financed, and I am not asking you for an answer at the moment, but if I may state the question, and then leave it to your good judgment to provide us with whatever information you can.

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DR. EDGECOMBE: Yes.

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to offer us some advice as to how such a program should be financed, and I am not asking you for an answer at the moment, but if I may state the question, and then leave it to your good judgment to provide us with whatever information you can.

We would like to know from you how such a program could be financed; where the money would come from. Perhaps you could make this information available with whatever supplementary information you wish to send to the Commission at a later date.

DR. EDGECOMBE: I can do that, yes.

COMMISSIONER McCUTCHEON: When you are preparing that information, I assume any comparison you make between per capita costs in the United States, or any conclusions you draw from per capita costs in the United States, will take into account that, as far as I know, there is no comprehensive prepaid dental scheme in force in the United States, which presumably, if it were in force, might increase those per capita costs.

DR. EDGECOMBE: They have quite a few schemes in the United States that are on prepayment basis -- more or less on a premium basis -- that are in the experimental stages now.

COMMISSIONER McCUTCHEON: Any information about those particular schemes would be very useful.

THE CHAIRMAN: Most useful, yes.

Is there anything else you would like to add, gentlemen? That is all, thank you. Thank you very much for your presentation and assistance.

The next submission will be from the New Brunswick Dental Technicians' Association.

--- EXHIBIT NO. 41: Brief of the New Brunswick Dental Technicians' Association

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Is there anything else you would like to add, gentlemen? That is all, thank you. Thank you very much for your presentation and assistance.

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--- RUPERT MC.MC. Brief of the New Brunswick Dental Technicians' Association.

SUBMISSION OF THE NEW BRUNSWICK DENTAL TECHNICIANS' ASSOCIATION

Appearances: Mr. Howard D. Lowerison, President
Mr. Fred E. MacLean, Second Vice-President
Mr. Robert G. Barton, Director
Mr. A. McF. Limmerick, Q.C., Counsel

MR. LIMMERICK: Mr. Chairman, ladies and gentlemen, we have a very short brief. I am not prepared to speak on the brief, but the members of the Association are here. I prepared it on their instructions, and I trust they will be able to answer any questions on it.

The New Brunswick Dental Technicians Association was incorporated by Chapter 71 of the Acts of the Legislative Assembly 1957 for the purpose of controlling the apprenticeship study, examination, registration and disciplining of dental technicians, and ensuring the proper qualification of persons engaged in the craft in the province. The membership of the Association comprises 28 members.

Under the present legislation in most if not all of the provinces of Canada, contained in the respective Dental Acts of the provinces, the practice of dentistry, which is forbidden under penalty except to those persons registered or licensed under the Acts in the several provinces as dentists, is defined to include "the taking of impressions of the mouth or any part thereof for, or fitting in the mouth of, dentures, plates or other artificial contrivances".

The result of this is that dentures or plates must be prescribed by and impressions for the same made by

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The result of this is that dentures or plates must be prescribed by and impressions for the same made by

dentists who may thereafter manufacture the denture or plate themselves or have the same manufactured by prescription by a qualified dental technician. As a result the cost of such prosthetic devices is high and often prohibitive to persons particularly in the lower income brackets.

The Association does not favour socialized medicine, but if a system of socialized medicine is instituted it is submitted that properly qualified and registered or licensed denturists should be permitted to engaged in the practice of the full denture field, from impression to insertion and fitting without in any way limiting the right of dentist to practise in the same field.

The above submission is made of on the following grounds: -

1. Many dental technicians are presently competent to do such work, but are prevented from doing so by the Dental Acts.

2. The demand for dental work in Canada is far in excess of the supply of dentists, the advertised proportion being one (1) dentist for every three thousand (3,000) of population, and socialized medicine, including dentistry would greatly increase the demand and the load on dentists.

3. The practice of preventative dentistry is becoming increasinly important and will occupy more of the time of registered dentists.

4. The costs of dentures can be reduced by removing the necessity of employing two persons, the dentist and the dental technician, where the full work can be done by one person.

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4. The costs of dentures can be reduced by removing the necessity of employing two persons, the dentist and the dental technician, where the full work can be done

5. The restricted field of dental technicians has resulted in a noticeable failure of new members entering the craft, and an elargement of the field, with proper safeguards as to qualifications could result in more persons entering the field and providing much needed service to the public.

The Association suggests that the qualifications of denturists should include the present requirements for registration under the Dental Technicians Acts of the several provinces together with an adequate knowledge of facial anatomy and that practice by denturists should be restricted to oral appliances requiring no cutting of tissue. In any case involving oral malformation including cancer, pyorrhoea and other diseases of the mouth, the denturists should be required to refer the case to a qualified dentist.

The Association further suggests that the present cost of denture material is too high and that some method for the procurement of material through government sources might be considered with a view to keeping production costs at a reasonable level.

Dated this 19th day of October, 1961.

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The association's present view that the qualifications of denturists should include the present requirements for registration under the Dental Technicians Acts of the several provinces, together with an adequate knowledge of facial anatomy and that practice by denturists should be restricted to oral appliances requiring no cutting of tissue. In any case involving oral malformation including cancer, pyorrhoea and other diseases of the mouth, the denturists should be required to refer the case to a qualified dentist.

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Dated this 19th day of October, 1961.

In regard to the proportion of dentists, I noticed with interest the submission of the last brief, and I have noticed on television, although I do not know from which source, that the average for Canada is one dentist for every 3,000 of population.

The main point in the brief is the suggestion of the Association that the present restriction under which dental technicians are required to prepare dentures only on prescription, and cannot, themselves, take a simple impression or repair plates except under prescription of a dentist, is restrictive, and that it is not reasonable in many cases, and that an opening of the field with proper safeguards would provide better and more reasonably priced care for the public generally.

THE CHAIRMAN: You state the position that you are against socialized medicine: what do you mean by "socialized medicine"?

MR. LIMMERICK: Again on instructions from the Society, they are not in favour of a system of prepaid dental, socialized or medical care.

THE CHAIRMAN: Are those words synonymous? Are they synonymous to your organization -- "prepaid scheme"?

MR. LOWERISON: We feel under the present situation the dentist today is getting so much per denture ---

THE CHAIRMAN: I am talking about this basic principle. You have in your brief the categorical statement that you are against socialized medicine. By "socialized medicine" do you mean -- I am taking that to

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include socialized health services, so far as you are concerned -- does that include any program of prepaid medical services?

MR. LOWERISON: I don't believe so entirely, no.

THE CHAIRMAN: On a comprehensive basis; that is, including all people.

MR. LOWERISON: Yes. I think it was the fact that we have one dentist for every 3,000 people, and as I think the Dental Society mentioned earlier, that is the reason we don't feel that they could handle the work.

THE CHAIRMAN: Now, that is not the proposition, is it? Let us assume for a moment there are enough dentists: would you be opposed to a comprehensive medical services program, prepaid?

MR. LOWERISON: No.

MR. MacLEAN: No.

MR. LIMMERICK: Probably my instructions were not too clear, and that this is based on the present circumstances.

THE CHAIRMAN: Is this putting it correctly, that your principal objection at the moment is the limitation imposed on you by the Dental Act of the Province of New Brunswick?

MR. LOWERISON: Yes.

THE CHAIRMAN: ...which says that if you do such-and-such that you are practising dentistry and makes you liable to a fine?

MR. LOWERISON: That is right, sir.

MR. LOWERISON: I don't believe so entirely, no.

THE CHAIRMAN: On a comprehensive basis;

MR. LOWERISON: Yes. I think it was the

THE CHAIRMAN: Now, that is not the proposition, is it? Let us assume for a moment there are enough dentists: would you be opposed to a comprehensive medical services program, prepaid?

MR. LOWERISON: No.

MR. MacLEAN: No.

were not too clear, and that bias is based on the present circumstances.

THE CHAIRMAN: Is this putting it correctly, that your principal objection at the moment is the limitation imposed on you by the Dental Act of the Province of New Brunswick?

MR. LOWERISON: Yes.

THE CHAIRMAN: ...which says that if you do such-and-such that you are practising dentistry and makes you liable to a fine?

THE CHAIRMAN: I don't know if you are prepared to say this, but have you given consideration to where that might come within our Terms of Reference -- your difficulty come within the Terms of Reference of this Commission?

MR. LIMMERICK: I think, Mr. Chairman, it probably comes in the same category as the matter which the dentists raised as to their difficulty of admitting patients to hospitals. It is a matter of local control in the Province entirely within the jurisdiction of the Provincial Government to handle, and they felt the matter should be raised because it is a matter of general public importance.

THE CHAIRMAN: Do you consider yourselves to come within the definition of "adequate health personnel"?

MR. LOWERISON: Yes, we do.

COMMISSIONER STRACHAN: Referring to paragraph 1, where you use the word "competent": by what means have you become competent, and what proof have you that you are competent, or, if I may put it another way, do you compare your competency favourably with the man who has been trained for four or five years in dental school and practising for from one to fifty years?

THE CHAIRMAN: I take it this is not an individual question? This is a question put on a group basis?

COMMISSIONER STRACHAN: To whoever wishes to answer it.

THE CHAIRMAN: But it is not referring to

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to answer it.

THE CHAIRMAN: But it is not referring to

the individual competency of these people?

COMMISSIONER STRACHAN: No.

MR. MacLEAN: My name is Fred MacLean and I am a dental technician in St. John and operate a lab, and as dentistry is practised now, as we are talking about plates, at one time making a denture in a dental office for a dentist was considered an operation. Now, as they are busy with the prosthetic end of it, the platework is a fill-in between patients, and I believe that way, as a fill-in, they are not giving it the time that they should, and it is putting more work on the dental technician, to do the work that they either haven't time to do or, through the pressure of operative dentistry, they don't care to do. Therefore, the technicians, if they are doing part of it, they might as well do all of it, and I am of the opinion that they could make a denture equally as well as the dentures that are being made by dentists today.

COMMISSIONER STRACHAN: By what right can you say it is a fill-in? Have you been in a dental office to experience that? Has a dentist assured you it is a fill-in?

MR. MacLEAN: No, I doubt if I could ever get him to assure me it was a fill-in.

COMMISSIONER STRACHAN: On what basis do you make the statement?

MR. MacLEAN: They have their appointments at possibly 2 o'clock and 2.30: well, they put in between patients an impression or a bite, and sometimes the dentist will say he was rushed at the time, and when the bite or denture comes into the lab to be made, that he

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didn't have the time for it -- pressed for time.

THE CHAIRMAN: Let us put it this way: what professional training does the dental technician have to go through before he can set himself up in business as a dental technician?

MR. LOWERISON: There are a few schools that the technician can attend. A lot of us have had training in the Army. I attended the dentists' school in Toronto as well as a lot of the other chaps, but actually I think a lot of the training of technicians is done in the lab, and you are taught by other technicians. In fact, there are practically none learning today. There are very few apprentices, if any -- in fact, there are none in the Province.

THE CHAIRMAN: If the dental technician disappears and becomes obsolete because nobody enters the business, who will then make the plates?

MR.LOWERISON: I don't know that, but it is likely to become obsolete unless this change is made.

MR. BARTON: Regarding the training, if I may say so, for my own part I have found that a great deal of incentive towards getting training has come from dentists, and a great deal of advice and experience has come from them. They all have different ways of doing things, and I found out which was the most successful, and that is the method I apply, but all dentists have their own way of doing things, and a great deal of experience comes from that source.

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COMMISSIONER STRACHAN: I would like to ask what ability a dental technician would have to diagnose

the presence of cancer, pyorrhea or other diseases of the mouth? What training have you had in pathological conditions or the recognition of them? You state that it would be required to refer the case to a qualified dentist.

MR.LOWERISON: I am sure that any qualified technician who saw any type of inflammation or infection of any sort would refer it to a dentist. They would not touch it all. They may not know whether it is cancerous or what it is, but they certainly would be smart enough not to touch it.

COMMISSIONER STRACHAN: Then, you would like to have the preferred cases?

MR. LOWERISON: Well, I think this could be worked hand-in-hand.

COMMISSIONER STRACHAN: You make a suggestion that the price of materials could be lowered: have you any definite suggestions as to how that could be done?

MR. BARTON: Indeed we have, sir. I don't know of any material you can buy in this world that is more expensive than dental materials. A lot of the stuff is put out with very expensive premiums in order to get you to buy their product. For instance, our plastic, which we use, one line comes in and has a great big premium worth over $13 in it, and are paying $75. We have tried to get them to throw the premiums out. We don't want these fancy dishes. We want material, but they say "No, this is our policy". On the other hand, if the Government could buy the stuff in bulk and under a socialized system we could very likely do away with a lot

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of this over-expense and over-advertising and save ourselves money -- and yourselves. That goes all the way through the line.

COMMISSIONER STRACHAN: You use the word "denturist": are there any as such recognized in any of the Provinces of Canada?

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You use the word "denturist": are there any as such recognized in any of the Provinces of Canada?

MR. MacLEAN: In certain Provinces I believe they have Acts whereby technicians are allowed to take impressions.

COMMISSIONER STRACHAN: I have used the word "denturist".

MR. MacLEAN: In British Columbia I believe there are ones who have been proved to have practised dentistry illegally, and they are lawbreakers. They are allowed to do it, but they are not named as denturists.

COMMISSIONER STRACHAN: You are appearing here as a legal body suggesting that the Royal Commission should turn it into an illegal body. I think that would be beyond the ability or the right of this Commission, just as much as an abortionist would wish to be legalized.

MR. LIMMERICK: Is that quite a fair statement? All the Association is asking is that this Commission consider and make recommendations to the effect whereby dentists might enter the profession illegally. Certainly it is not by any means a request that you authorize them to do something illegally; it is a question of whether you consider in the interests of public health and providing facilities for public health that this would be advisable. I think this is a fair statement.

THE CHAIRMAN: Anything further to add, gentlemen?

MR. MacLEAN: I might add that we were prompted to submit this brief to the Commission with the pressure of the public on myself, as a lab operator, and my friend Mr. Barton here by the public asking us to make

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or repair dentures for them. I think we should think about these people, and that is what prompted us to do this.

THE CHAIRMAN: Do you make a distinction between making dentures and repairing dentures?

MR. LOWERISON: From the beginning, when a person has their teeth taken out, you make new dentures, but repairing dentures is repairing it when one is broken.

THE CHAIRMAN: Can you do that now without prescription?

MR. LOWERISON: No.

THE CHAIRMAN: You must have a prescription for this?

MR. LOWERISON: Yes.

COMMISSIONER STRACHAN: Mr. Chairman, I would like to point out that licenses are essential in so many trades and professions. We are not even allowed to go ahead and do any electrical work or plumbing in our homes; it must be passed, when done by a qualified man, for inspection. The practice of dentistry is a recognized part of our society, and it is with law and medicine and other professions, and there must be limitations on what they can do for the protection of the public.

THE CHAIRMAN: Very well, gentlemen. Thank you very much, Mr. Limmerick.

The next submission is that of the New Brunswick Pharmaceutical Society.

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THE CHAIRMAN: Very well, gentlemen. Thank you very much, Mr. Hammerton.

The next submission is that of the New [illegible] Dental Society.

SUBMISSION OF THE NEW BRUNSWICK

PHARMACEUTICAL SOCIETY.

--- EXHIBIT NO. 42: Submission of the New Brunswick Pharmaceutical Society.

Appearances: William R. Townsend
George A. Noble

MR. NOBLE: Mr. Chairman, ladies and gentlemen of the Commission, my name is George Noble, solicitor for the New Brunswick Pharmaceutical Society. I am sorry to point out to the Commission that our brief wasn't sufficient in length, but one of the troubles that we had with it was that there was so much material that we shortened it down. This is a preliminary brief which has been presented, and due to the shortness of time we wish to state that we would like to put in further statistics at a later date.

THE CHAIRMAN: That will be quite satisfactory, Mr. Noble.

MR. NOBLE: Thank you, Mr. Chairman. I would like to introduce Mr. William R. Townsend, Bachelor of Science Degree from the University of New Brunswick in 1950, and Pharmaceutical Chemist from the College of Pharmacy. He has been a member of the Society for four years. He is the New Brunswick delegate to the Canadian Pharmaceutical Association, and at present the President of the New Brunswick Pharmaceutical Society.

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I

SUMMARY OF CONTENT OF THE PRELIMINARY BRIEF BY THE NEW BRUNSWICK PHARMACEUTICAL SOCIETY

(1) It is recognized that problems do exist with regard to pharmaceutical services and drug distribution and a comprehensive analysis of the foregoing is contingent upon the development of reliable and accurate statistics. On the basis of preliminary statistics submitted, it is suggested that drug costs would not be a deterrent to adequate drug therapy for most individuals. (Sections 8, 9, 10 and Appendix "E").

(2) There is a trend to urbanization which precludes the development of adequate Pharmaceutical Service Facilities in rural areas. (Section 12("C"))

(3) At the present time Pharmacists are not being fully utilized by the hospitals of the Province or by the Department of Health. It is recommended that all hospitals of over 30 beds employ a full time Pharmacist and that all hospitals under 30 beds employ the local Pharmacist on a part time basis where feasible. It is also recommended that a Consultant Pharmacist be employed by the Department of Health. (Section 12(D) and (E).

(4) Regarding the problem of dispensing Physicians it is recommended that physician dispensing should not be permitted in those areas which are served by properly staffed pharmacies. (Section 12(F) and (G).

(5) It is suggested that bona-fide Charitable Health and/or Welfare Organizations be subsidized by the Government in respect to indigent patient drug costs, and that the question of cost be thoroughly reviewed before

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and/or Welfare Organizations be subsidized by the Government in respect to indigent patient drug costs, and that the question of cost be thoroughly reviewed before

any change in the system of distribution is considered. (Section 14).

(6) The Society endorses the Statement of Policy of the Canadian Pharmaceutical Association regarding manpower as set out in Appendix "D" of their preliminary brief. (Section 16).

(7) It is suggested that solution to the problem of Generic or Nonprietary Prescribing is contingent upon Federal Legislation to insure quality control and licensing of all manufacturers. (Section 19).

(8) It is respectuflly suggested by the New Brunswick Pharmaceutical Society that it is the inherent nature of the public, as a whole, to use to excess services which are apparently provided free and to this, the Society suggests a careful study of possible controls. (Section 21).

(9) The New Brunswick Pharmaceutical Society wishes to reserve the right to submit additional material at subsequent Commission hearings.

(10) It is the opinion of the Society that any Comprehensive Health Care Plan should include:

(1) Legally authorized and regulated outlets for drugs with all pharmaceutical services to be supplied directly to the public only through a Pharmacist.

(2) Pharmacist representation on anybody charged with the development and administration of policies pertaining to pharmaceutical services.

(3) Freedom of choice of a pharmacist by the patient.

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SUBMISSION

to the

ROYAL COMMISSION ON HEALTH SERVICES

by the

NEW BRUNSWICK PHARMACEUTICAL SOCIETY

INTRODUCTION:

1. This submission is respectfully made to the Royal Commission on Health Services by the New Brunswick Pharmaceutical Society. This Society was incorporated in 1884 by an Act passed by the Provincial Government and has continued and is presently governed by Chapter 77 of the Revised Statutes of New Brunswick, 1958, and Amendments thereto, the terms of which regulate the sale of drugs and prescriptions, and a summary of the provisions of the New Brunswick Pharmaceutical Act, 1958, is attached to this submission as Appendix "A".

2. There are two governing Federal Acts of the Pharmaceutical Act in New Brunswick which are, namely:

(a) The Narcotic Control Act which is attahced to this submission as Appendix "B";

(b) and The Food and Drugs Act which is attached to this submission as Appendix "C:.

3. Certain terms and definitions are defined in Appendix "D" attached hereto.

4. Membership of the Society consists of 165 Registered Pharmaceutical Chemists. Certified clerks are registered under the Act, but are not members of the Society, and there are the present time 112 certified clerks registered.

5. There are no drug manufacturing establishments

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in New Brunswick. These firms carry on business through the wholesalers and at the present time they operate through four wholesale drug outlets. There are 103 retail drug outlets in the Province.

6. Members of the Society participate actively in the following national organizations serving pharmacy and the Canadian public:

(a) Canadian Pharmaceutical Association.

(b) Canadian Society of Hospital Pharmacists.

(c) Canadian Foundation for the Advancement of Pharmacy, and

(d) Canadian Conference of Pharmaceutical Faculties.

7. The Society participates in the Atlantic Provinces Pharmaceutical Advisory Council (APPAC) an advisory body, which as the name indicates is composed of members from the three Maritime Provinces, namely: Nova Scotia, Prince Edward Island, and New Brunswick, and is an association for the betterment of pharmacy and the service rendered by the pharmacists to the public. This regional council will be submitting a brief with regard to education of pharmacists at a later date when the Commission resumes their hearings in Ottawa.

8. Areas and problems pertaining to Pharmacy.

(a) Provision of drugs and pharmaceutical services through retail drug outlets. From detailed statistical information and from a survey by the New Brunswick Pharmaceutical Society of its members an amount of $3,425,000.00 is estimated to be the total prescription dollar volume in New Brunswick. See Appendix "E", Part

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(1) for estimated Prescription dollar volume.

(b) Distribution of drugs through the Provincial Government Departments, Hospitals, and Clinics: An amount of $1,220,992.00 is reported to be drug cost incurred. See Appendix "E", Part (2).

(c) Distribution of drugs through the Federal Government Agencies: (D.V.A. and Canadian Armed Forces).

At present these figures are unavailable, but an attempt will be made to have them at a later date in order to complete the summary of drug costs in New Brumswick.

9. Based on the figures calculated in Appendix "E", it is estimated that the present retail drug store prescription dollar volume in New Brunswick is between three and one-half million and five and one-half million dollars with all evidence indicating it is in excess of four million dollars.

10. Conclusions which can be based on these estimates: The average cost per prescription is approximately $3.00 and the number of estimated prescriptions per person exceeds 2.5 per annum. On this basis the average per capita drug cost is $7.50 per annum. Based on the foregoing, it is suggested that drug costs would not be a deterrent to adequate drug therapy for individuals.

11. Since drugs form an important and effective part of any health plan, the cost of the development, production, sale and distribution of drugs is borne by the patient. It can be easily seen that the cost of drugs represents one of the major portions of the

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11. Since drugs form an important and effective part of any health plan, the cost of the development, production, sale and distribution of drugs is borne by the patient. It can be easily seen that the cost of drugs represents one of the major portions of the

expense involved in total medical care and treatment of the patient, or in any plan proposed or developed thereunder.

12. Deficiencies in the Present Method of Providing Drugs and Pharmaceutical Services

(A) In general, there are two main outlets for Drugs in the Province of New Brunswick. One is the retail Pharmacy, and the second is the Hospital Pharmacy, which supply drugs direct to the patient. Both hospital and retail pharmacies purchese these Drugs either through a wholesaler or direct from the manufacturer. In New Brunswick we have no Drug manufacturers. There are four wholesale drug outlets. Also, it should be noted that the grocery wholesaler carries an increasing line of non-scheduled drugs for over-the-counter sales. This volume of course, could not be even estimated by the New Brunswick Pharmaceutical Society.

(B) Beside the above two main outlets there are other outlets direct to the consumer such as improperly staffed Medical Centers, (see Appendix "F"), Door-to-Door salesmen, Industrial Accounts, Dispensing Doctors and samples from Doctors.

(C) It would appear that Pharmacy like most other allied Health professions

the patient, or in any plan proposed or developed thereunder.

12. Deficiencies in the Present Method of Providing Drugs and Pharmaceutical Services

(A) In general, there are two main outlets for Drugs in the Province of New Brunswick. One is the retail Pharmacy, and the second is the Hospital Pharmacy, which supply drugs direct to the patient. Both hospital and retail pharmacies purchase these Drugs either through a wholesaler or direct from the manufacturer. In New Brunswick we have no Drug manufacturers. There are four wholesale drug outlets. Also, it should be noted that the grocery wholesaler carries an increasing line of non-scheduled drugs for over-the-counter sales. This volume of course, could not be even estimated by the New Brunswick Pharma-

(B) Beside the above two main outlets there are other outlets direct to the consumer such as improperly staffed Medical Centers, (see Appendix "F"),

Accounts, Dispensing Doctors and samples

(C) It would appear that Pharmacy like

suffers from urbanization. Most of our retail Pharmacies are located within the major centres in New Brunswick and few in the outlying rural areas.

(D) Pharmacists in Hospitals. There are in New Brunswick forty hospitals which we can divide into two groups:

(a) 25 hospitals with over 30 beds,

(b) 15 hospitals with under 30 beds.

In order to provide the necessary protection for the patients in hospitals, the New Brunswick Pharmaceutical Society feels that the hsopitals in (a) category will operate more successfully and economically if they employ full-time registered pharmacists. This Pharmacist could act as a purchasing agent for drugs; he could use his professional knowledge in keeping drug inventories and preventing duplication of stock; he could assess new drug products; he would be of valuable assistance in the layout of a dispensary; he is competent to deal with slow moving and outdated products.

The New Brunswick Pharmaceutical Society acknowledges that in (b) category (under 30 beds) it would not actually be feasible to hire a full-time pharmacist for the hospital. We do, however, recommend that the rural hospital hire on

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a part-time basis the local pharmacist. This would accomplish two pursposes; it would help the hospital to give adequate drug service and it would serve as an inducement for the Pharmacist to locate in an unserviced rural area if such a system was adopted. These pharmacists would be as much help on a part-time basis to the small hospitals as a full-time pharmacist would be to the major hospitals.

(E) Hospital Services Division of the New Brunswick Department of Health.

Following the pattern of Nova Scotia, Saskatchewan, Alberta, British Columbia and Ontario, where complete hospital compensation has been established, we recommend to the Hospital Services Division, Department of Health, that a consultant pharmacist be hired. This Pharmacist would be instrumental in laying down basic policy for all New Brunswick Hospital Dispensaries. He could assess and advise on products, help with the layout of hospital dispensaries and be responsible to the Government for the dispensing of drugs within the hospitals according to the provisions of the New Brunswick

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Pharmaceutical Society and the hospitals of the Province.

(F) Sample of Drug Products Given Out by Doctors.

The New Brunswick Pharmaceutical Society has no method of ascertaining the amount of samples which are given out to the Medical Doctors. We respectfully submit that this facet has been completely explored by the "Material Collected for Submission to the Restrictive Trade Practises Commission in the Course of an Inquiry under Section 42 of the Combines Investigation Act" which recommendation will be on record very shortly.

(G) Physician Dispensing.

In sparsely populated rural areas, of which there are many in this province, it is a necessity that the Physician be his own Pharmacist and dispense the drugs which he prescribes. However, in the main, it is generally recognized and usually defined by Legislation that the Pharmacist does not practise medicine and the Physician does not practice pharmacy.

With the exception of those areas just mentioned where it is economically impossible for the pharmacy to be

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With the exception of those areas just mentioned where it is economically impossible for the pharmacy to be

operated, all dispensing should be done by Pharmacists. Every patient deserves first class uncompromised health services. An integral part of these health services is a proper Pharmaceutical Service.

The dispensing Physician is criticized because his stock of pharmaceuticals cannot compare with the complete inventories of a pharmacy. Because of this fact, there is substantial reason to believe that a dispensing physician compromises the type of health service, especially in regard to the pharmaceutical aspects of that service, when such a physician prescribes for and then dispenses to a patient. The prescribing of such a dispensing physician is conditioned or limited by his stock of drugs rather than by the demands of the clinical condition for the best pharmaceutical product and the treatment of that condition.

Therefore, physician dispensing should not be permitted in those areas which are served by properly staffed pharmacies.

See Appendix "F". <u>An article by Dr. Edward L. Fitzgerald.</u>

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Therefore, physician dispensing should not be permitted in those areas which are served by properly staffed pharmacies.

See Appendix "D". An article by

13. Present Financing of Health Care. In general, the Pharmaceutical Health Services in the province would fall into four basic categories:

(1) Government Agencies (Municipal, Provincial and Federal).

(2) Medical Welfare Societies (Cancer Society and T.B. and Arthritis Society).

(3) Contributory Insurance Plans.

(4) Direct patient costs.

It is suggested that most of those interested parties, except number (4) above, will be submitting comprehensive briefs of their own to the commission, and therefore it would not be necessary for us to comment on this at this time.

14. It is difficult to identify the individuals or groups of people who bear the major burden of drug cost. However, it is felt that drug costs might prove a financial hardhsip to the following two groups which usually have high medical care costs.

(a) Those who are truly indigent. Regardless of how low or high the cost of drugs might be, these people cannot afford to pay for them.

(b) A second group here are those who are unable to support themselves or their families because of a lengthy illness. These groups are somes cared for by some form of social welfare.

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drugs issued by charitable health or welfare societies like the Canadian Cancer Society, which is a bona fide charitable organization, be subsidized by the Government in respect to expenditures for drugs, dressings, and other supplies usual to their services in the case of indigent patients.

(2) The New Brunswick Pharmaceutical Society does not necessarily favour a National Health Scheme since there is an accumulation of evidence to support the contention that health care generally in the United Kingdom is much more expensive since the inception of their National Health programme than before. Therefore, we would ask that the Government consider the continuance of the present system of distribution and we support our request with evidence of lack of hardship on any but the most unusual patient. Now that the Province has entered into this field, we feel that the large majority of those few patients who were burdened with large medical and pharmaceutical bills, are in most cases hospitalized and now receive these services without direct cost. It is felt that any National Health Service will cost the Government a good deal more money than the distribution at the present time.

16. Manpower. We endorse the proposals of the Canadian Pharmaceutical Association with their suggestions on the utilization of manpower and recommend that the research staff of the Commission together with the Canadian Pharmaceutical Association instigate such a survey.

See Appendix "D", Canadian Pharmaceutical

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Association preliminary brief.

The New Brunswick Pharmaceutical Society pledges its co-operation in this matter.

From a survey of the Pharmaceutical Society taken in this province, we feel that a minimum of twenty-five new pharmacists are urgently needed, this would be to staff institutions and retail pharmacies already in operation.

There are nine registered pharmacists employed in hospitals in the province and as can be seen by the number of hospitals, this does not assure pharmaceutical services to the majority of the larger hospitals and it shows that there is a need for more pharamacists in this field.

17. Drug Utilization. New Brunswick at the present time needs more registered pharmacists since the demand for pharamaceutical services in increasing rapidly. Due to more drugs being introduced, new important products being available, and increased participation in contributory health plans, there is an increase in drug demands at the present. Hospitals are now being used to greater capacity due to proper use of more advanced medication. In our hospitals there is a need for a well-qualified pharmacist specializing in the developing fields of medicine and this need will become greater as research in applied medicine increases in scope. It has been recommended by the Society in order to supply future demands that an expanded and advanced academic training program was needed. A new College of Pharmacy with an extended course of four years duration

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at Dalhousie University has been introduced and will be more fully developed on the APPAC Brief on Education which will follow.

18. The New Brunswick Pharmaceutical Society realizes that expert opinion is necessary in dealing with the technical and professional aspects of pharmacy and this society believes that only a pharmacist can provide this expert opinion with regard to pharmacy and humbly requests that the Health Commission appoint a consultant pharmacist to their advisory board. This Society concurs with the Canadian Pharmaceutical Association in regard to the submission on this point in their brief.

19 (A) Nomenclature and Existing Drug Legislation

The following excerpt is taken from an article written by Lloyd C. Miller, Ph.D., New York City, in "The Journal of the American Medical Association" Volume 177, No.1, dated July 8, 1961, entitled "Doctors, Drugs and Names."

"The multiplicity of names for drugs is inevitable. In addition to the systematic chemical name for a given drug, there are the trivial names by which it may be known familiarly among chemists, the code number needed during research and development, the proprietary names needed when the drug is sold, and the generic name that is used as the common designation for all the various brands. The generic name, which is non-proprietary, is usually chosen by concerted action of representatives of manufacturing, medical, and governmental organizations. The medical profession would

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co-operate in the effort to minimize confusion by using accepted nonproprietary names."

Judgment of the suitability of generic or nonproprietary names depends entirely on the judge's point of view. Taking the view point of the manufacturer, the name need only be adequate to protect his trademark. Freedom from conflict with any other names used for drugs is an important attribute. It is evident that the convenience of all is served best when the nonproprietary names are as short as possible. Yet there is equal agreement on the proposition that the name should point up such relationships as exist among compounds that fall into a common pharmacological group.

We quote Dr. Morrell's statement, Page 13, of "Material Collected for Submission to the Restrictive Trade Practices Commission in the Course of an Inquiry under Section 42 of the Combines Investigation Act."

"When it comes to buying top-quality drugs, the things to check are the ability, facilities, personnel and conscience of the drug manufacturer".

"Neither a brand name nor a drug's generic name is the sole reliable guide to quality."

"The real point is who makes the drug and how it's made - the control system that insures careful and scientific testing for potency and stability."

To the best of our knowledge, no manufacturer needs a license to manufacture drugs, the exception being certain injectibles.

19 (B) Generic or Nonproprietary Prescribing.

This has been repeatedly advocated as a means

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19 (B) Generic or Nonproprietary Prescribing.

This has been repeatedly advocated as a means

of reducing prescription costs. Many such recommendations have been made on a complete misunderstanding of the significance of prescribing by generic name. When a physician prescribes a drug by a generic name, he authorizes the pharmacist to exercise his professional judgment in the selection of the manufacturer of the prescribed drug. The pharmacist assumes a complete responsibility for the quality of the medication that is dispensed. This does not imply that the pharmacist is morally or legally bound to fill the prescription with the cheapest medication available, but rather with a brand he knows is reliable. Only a small percentage of prescriptions loan themselves to the use of generic or nonproprietary names because of the high percentage of manufacturers specialties which are prepackaged compounds.

We further submit that the only method on non-proprietary prescribing would be (a) that the Federal Department of Health be responsible for all nonproprietary or generic names, (b) that all manufacturers must be licensed so that quality control would always be maintained as some manufacturers do not have quality control. The government should insist that this be immediately implemented and any costs of such a procedure be borned completely by the manufacturers concerned.

20. A projected cost programme could not be considered at this time since the returns of the Society were not complete, but it is the intention of the Society before the final brief is presented to prepare projected cost statistics.

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20. A projected cost programme could not be considered at this time since the returns of the Society were not complete, but it is the intention of the Society before the final brief is presented to prepare [illegible].

21. Summation.

(a) From evidence available the provision of drugs either on a free or contributary scheme is shown to be a most expensive undertaking. Since the patient now must pay the research, manufacturing, advertising and producing costs, so the same, if government assumes the obligation. It is then obvious that the costs must be borne by the public through increased taxation.

(b) The Utilization Rate. There is a tendency on the part of the public to over-utilize services which are free or contributary, more visits to the physician and more prescriptions thus more costs for the public to bear. We would suggest further study of possible deterrents for the purpose of controlling over utilization.

22. It is the opinion of the Society that any Comprehensive Health Care Plan should include:

(1) Legally authorized and regulated outlets for drugs with all pharmaceutical services to be supplied directly to the public only through a pharmacist.

(2) Pharmacist representation on anybody charged with the development and administration of policies pertaining to pharmaceutical services.

(3) Freedom of choice of a pharmacist by the patient.

(4) Freedom of the pharmacist to conduct all or any part of his professional practice outside of any health care programme if he

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so chooses.

In all cases costs of any Comprehensive Health Care Plan should be secondary to the precepts of good health services and care.

All of which is respectfully submitted.

William R. Townsend, B.Sc.,Ph.C.

President

New Brunswick Pharmaceutical Society

Dated at Fredericton, New Brunswick
this 24th day of October, 1961.

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William H. Ferguson, President

New Brunswick Pharmaceutical Society

Dated at Fredericton, New Brunswick

A

Appendix A
To Submission By The
New Brunswick
Pharmaceutical Society

SUMMARY OF PROVISIONS OF THE
NEW BRUNSWICK PHARMACEUTICAL ACT
R.S.N.B. 1958 CHAPER 77

The New Brunswick Pharmaceutical Society is a Statutory Society which is incorporated under the Legislature by the New Brunswick Pharmaceutical Act 1958 and the following is a summary of the provisions of the Act.

1-A The members of the Society shall consist of such persons as are now members thereof together with such persons as shall hereafter pursuant unto the provisions of this Act become registered as Pharmaceutical Chemists. The Society shall have the power to acquire and hold for its purposes real and personal property and may alienate, mortgage, lease, charge or dispose of the same or any part thereof and may erect buildings for the purpose of the Society and do all such things as may be incidental to these purposes.

2-A Council and Officers

There shall be a Council Society composed of twelve members which shall be elected an annual meeting from among those members of the Society who reside in the province and are in good standing.

3-A The Council shall at its first meeting after the annual meeting of the Society elect from among the members of the Council a President and a Vice-President

Appendix A
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3-A The Council shall at its first meeting after the annual meeting of the Society elect from among the

and also appoint a Secretary, a Treasurer and a Registrar who may, but need not be members of the Council. The offices of Secretary and Registrar may from time to time be held by the same person.

4-A The Council shall have the sole control and management of all property of the Society, but no real property shall be acquired, alienated, mortgaged, leased, charged or disposed of without previous authorization of the Society evidenced by a resolution passed by affirmative vote of majority of the members of Society present at an annual meeting. The Council may make by-laws and regulations not in consistence with the Act respecting

(a) the regulation of a meeting and proceedings of the Society and the Council,

(b) the appointment and remuneration of the officers and examiners of the Society,

(c) the holding and conduct of examination of candidates for registration as pharmaceutical chemists.

5-A The Council is responsible for the quality of the pharmaceutical chemists in New Brunswick, to this end it must appoint a board of examiners who shall meet at least once a year to examine the qualifications of all candidates who desire to be examined and registered as pharmaceutical chemists.

Registration (Sec. 13)

6-A Every candidate for registration as a Certified Clerk shall, in addition to passing the examination provided therefor, satisfy the Council that he has:

who may, but need not be members of the Council. The offices of Secretary and Registrar may from time to time be held by the same person.

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Registration (Sec. 13)

6-A Every candidate for registration as a Certified Clerk shall, in addition to passing the examination provided therefor, satisfy the Council that he has:

(a) Good moral character.

(b) Possession of a junior matriculation certificate or a certificate of equivalent standard approved by the Council.

(c) Not less than twenty-three months or three thousand hours service as an assistant to one or more registered pharmaceutical chemists in any one or more of the Provinces of New Brunswick, Nova Scotia and Prince Edward Island.

(d) Attended and successfully passed an elementary course at the Maritime College of Pharmacy or at any other college approved by the Council.

7-A (Sec.14)

Every candidate for registration as a pharmaceutical chemist shall, in addition to and before passing the examination provided therefore, satisfy the Council that he has:

(a) Good moral character.

(b) Passed the certified clerk's examination.

(c) Possession of a junior matriculation certificate or a certificate of equivalent standard approved by the Council evidencing marks of at least fifty per cent in each of the subjects listed as requirements on entrance to the Maritime College of Pharmacy.

(b) [illegible]

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(c) Possession of a junior matriculation certificate or a certificate of equivalent standard approved by the Council evidencing marks of at least fifty per cent in each of the subjects listed as requirements on entrance to the Maritime College of Pharmacy.

(d) attended and successfully passed a senior qualifying course in pharmacy at the Maritume College of Pharmacy or at any other college approved by the Council.

(e) served for not less than thirty-five months or forty-five hundred hours as an assistant under the supervision of one or more registered pharmaceutical chemists in any one or more of the Provinces of New Brunswick, Nova Scotia and Prince Edward Island, and for at least twelve of those months or fifteen hundred of those hours has been employed as a certified clerk in the dispensing of prescriptions.

8-A (Sec.15)

Every person who has satisfied the provisions above and who has paid all fees prescribed shall upon application be registered as a Pharmaceutical Chemist and be entitled to receive from the Society a diploma.

9-A <u>Shop Licences (Sec.24)</u>

Every person who carried on a business of pharmacy shall take out a shop license, from the Registrar of the Society, for the purpose in respect of each shop or place of business in which he conducts a pharmacy.

10-A (Sec.24)

To obtain such a license the applicant must:

(a) File with the Registrar in the form

(d) attended and successfully passed a senior qualifying course in pharmacy at the Maritime College of Pharmacy or at any other college approved by the Council.

(e) served for not less than thirty-five months or forty-five hundred hours as an assistant under the supervision of one or more registered pharmaceutical chemists in any one or more of the Provinces of New Brunswick, Nova Scotia and Prince Edward Island, and for at least twelve of those months or fifteen hundred of those hours has been employed as a certified clerk in the dispensing of prescriptions.

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10-A (Sec.24)

To obtain such a license the applicant must:

(a) File with the Registrar in the form

prescribed by by-law giving such information as may be thereby required.

(b) Furnish to the Registrar satisfactory evidence that the shop is under the bona-fide personal supervision of a pharmaceutical chemist.

(c) If so required, satisfy the Council that the applicant has in each such shop adequate and suitable stock and dispensing equipment and adequate and suitable reference library and that with respect to general cleanliness and sanitation and otherwise the premises, stock and dispensing equipment are suitable for compounding, dispensing and the sale of drugs and medicines.

(d) Comply with the by-laws and regulations of the Society respecting the issue of a shop license and the prescribed fee to be paid.

11-A (Sec.29)

Such a shop license shall be in the form prescribed by by-law and shall entitle the holder thereof to conduct, or have conducted in accordance with the provision of this Act a drug store in the premises designated in the license.

12-A (Sec.24)

The license shall be an annual license and shall be enforced for the term of one year on a date fixed by the Council.

prescribed by by-law giving such information as may be thereby required.

(b) Furnish to the Registrar satisfactory evidence that the shop is under the bona-fide personal supervision of a pharmaceutical chemist.

(c) If so required, satisfy the Council that the applicant has in each such shop adequate and suitable stock and dispensing equipment and adequate and suitable reference library and that with respect to general cleanliness and sanitation and otherwise the premises, stock and dispensing equipment are suitable for compounding, dispensing and the sale of drugs and medicines.

(d) Comply with the by-laws and regulations of the Society respecting the issue of a shop license and the prescribed fee to be paid.

Such a shop license shall be in the form prescribed by by-law and shall entitle the holder thereof to conduct, or have conducted in accordance with the provision of this Act a drug store in the premises designated in the license.

12-A (Sec.24)

The license shall be an annual license and shall be enforced for the term of one year on a date fixed by the Council.

13-A (Sec.25)

Every drug store shall be under the personal supervision of a bona-fide pharmaceutical chemist. No pharmaceutical chemist shall be competent at any one time to exercise personal superintendence over more than one store.

14-A Sale of Poisons and Drugs (Sec.27)

No person shall sell any article named in Schedule A part two (see Appendix A) or any article named and marked with an asterisk in Schedule A part three either by wholesale or retail unless the box, bottle, vessel, wrapper or cover in which the poison is contained is distinctly labelled with the word "poison" and if so by retail then also with the name and address of the proprietor of the establishment in which it is sold.

15-A (Sec.28)

The articles or preparation thereof mentioned in Schedule A part one may be sold only to or on the prescription of a legally qualified medical practitioner, dentist or veterinary surgeon.

16-A (Sec.29)

The articles mentioned in Schedule A part two and part three may be sold only to a person who in the judgment of the seller is purchasing any such article in good faith for its proper use.

17-A (Sec.29)

On every sale of any article mentioned in Schedule A part two the person selling the same shall before delivery make an entry in a book to be kept for that purpose in the form set forth in Schedule C to this

Every drug store shall be under the personal supervision of a bona-fide pharmaceutical chemist. No pharmaceutical chemist shall be competent at any one time to exercise personal superintendence over more than one store.

14-A Sale of Poisons and Drugs (Sec.27)

No person shall sell any article named in Schedule A part two (see Appendix A) or any article named and marked with an asterisk in Schedule A part three either by wholesale or retail unless the box, bottle, vessel, wrapper or cover in which the poison is contained is distinctly labelled with the word "poison" and if so by retail then also with the name and address of the proprietor of the establishment in which it is sold.

15-A (Sec.28)

The articles or preparation thereof mentioned in Schedule A part one may be sold only to or on the prescription of a legally qualified medical practitioner.

The articles mentioned in Schedule A part two and part three may be sold only to a person who in the judgment of the seller is purchasing any such article in good faith for its proper use.

17-A (Sec.29)

On every sale of any article mentioned in Schedule A part two the person selling the same shall before delivery make an entry in a book to be kept for that purpose in the form set forth in Schedule C to this

act (see Appendix B) stating the date of sale, the name and address of the purchaser, the name and quantity of the article sold and the purpose for which it is stated by the purchaser to be required.

18-A Offenses and Penalties (Sec.39)

Disciplinary powers of the Society, the Council may of its own motion and shall on the application of any person inquire into and determine any matter of complaint against any member of the Society where it is in substance alleged or the Council has reasonable grounds for believing that such a member has been guilty of:

(a) Any offence against any act of Parliament of Canada or the legislature of New Brunswick relating to the sale of Narcotics, Drugs, Poisons or Alcoholic Liquors.

(b) Professional misconduct or conduct unbecoming to one who has the responsibility of practising pharmacy and selling drugs and poisons and particularly when such conduct is in respect to the use of Narcotic Drugs, Poisons or Alcoholic Liquors.

(c) A breach of any of the provisions of this Act or any regulation made hereunder, the Council may appoint from the membership of the Society a committee of not less than three to hold any such inquiry.

act (see Appendix B) stating the date of sale, the name and address of the purchaser, the name and quantity of the article sold and the purpose for which it is stated by the purchaser to be required.

Disciplinary powers of the Society, the of any person inquire into and determine any matter of in substance alleged or the Council has reasonable grounds for believing that such a member has been guilty of:

(a) Any offence against any act of Parliament of Canada or the Legislature of New Brunswick relating to the sale of Narcotics, Drugs, Poisons or Alcoholic Liquors.

(b) Professional misconduct or conduct unbecoming to one who has the responsibility of practising pharmacy and selling drugs and poisons and particularly when such conduct is in respect to the use of Narcotic Drugs, Poisons or Alcoholic Liquors.

(c) A breach of any of the provisions of this Act or any regulation made hereunder, the Council may appoint from of not less than three to hold any such inquiry.

19-A (Sec.39)

When such an inquiry is held the Committee shall report to the Concil its findings and such recommendations as the Committee or majority thereof may deem advisable, such report shall be made in writing and signed by the members of the Committee concurring therein and there shall be included in or attached to such report the Minutes of the Proceedings before the Committee, the evidence adduced and all exhibits produced, or copies thereof.

20-A (Sec.39)

If the Council after holding an inquiry or upon receiving a report from the Committee of investigation considers the matter of complaint well founded, it may order that the registration of the person whose conduct has been under inquiry be cancelled or that he be suspended from practising for such a period as the Council may deem proper, or the Council may take such other order as they deem just.

21-A (Sec.39)

Any person to whom a certificate shall be denied by the Council, or whose registration has been ordered cancelled by the Council, or who has been suspended from practising under the provisions of this Act, may appeal such an order of the Council to any judge of the Supreme Court within three months from the date of order and the judge upon hearing os such appeal may make such order to the granting of a diploma or certificate or the restoration of the registration or confirming or varying the order or decision of the Council or for

When such an inquiry is held the Committee shall report to the Council its findings and such recommendations as the Committee or majority thereof may deem advisable, such report shall be made in writing and signed by the members of the Committee concurring therein and there shall be included in or attached to such report the Minutes of the Proceedings before the Committee, the evidence adduced and all exhibits

20-A (Sec.39)

If the Council after holding an inquiry or upon receiving a report from the Committee of investigation considers the matter of complaint well founded, it may order that the registration of the person whose conduct has been under inquiry be cancelled or that he be suspended from practising for such a period as the Council may deem proper, or the Council may take such other order as they deem just.

21-A (Sec.39)

Any person to whom a certificate shall be denied by the Council, or whose registration has been ordered cancelled by the Council, or who has been suspended from practising under the provisions of this Act, may appeal such an order of the Council to any Judge of the Supreme Court within three months from the date of order and the Judge upon hearing on such appeal may make such order to the granting of a diploma or certificate or the restoration of the registration or confirming or varying the order or decision of the Council or for

further inquiries of the Council into the case and as to cost as shall be just.

22-A (Sec.39)

No action shall lie against the Council or any committee or member thereof for any proceedings taken in good faith or oders made or enforced under the disciplinary provisions of this Act.

further inquiries of the Council into the case and as to cost as shall be just.

(Sec. 13)

No action shall lie against the Council or any committee or member thereof for any proceedings taken in good faith or dones made or enforced under the disciplinary provisions of this Act.

NEW BRUNSWICK PHARMACEUTICAL ACT

SCHEDULE A

Articles or preparations thereof may be sold only to a medical practitioner, dentist, or veterinary surgeon, or on the prescription of a medical practitioner, dentist or veterinary surgeon:

1. A-methopterin (4-amino-N10-methylpteroyglutamic acid) and its salts.
2. Amino-an-fol (4-aminopteroylaspartic acid) and its salts.
3. Aminopterin (4-amino-pteroyglutamic acid).
4. Aminopyrine, and any salt, homologue or derivative thereof and preparations containing aminopyrine and any salt, homologue or derivative thereof.
5. Amphetamine, and any salt thereof; and preparations containing ampetamine or any salt thereof.
6. Apiol and preparations containing apiol.
7. Atropine, and its salts; and internal preparations containing more than 1/500 gr. per stated dose, or other preparations containing more than 0.1% by weight.
8. Barbituric acid, and any salt, homologue or derivative thereof, and preparations containing barbituric acid or salt, homologue or derivative thereof.
9. Bishydroxycoumarin, its salts and derivatives including Dicumarol, Cumopyran and Tromexan.
10. Bisulfan.

SCHEDULE A

Articles or preparations thereof may be sold only to a medical practitioner, dentist, or veterinary surgeon, or on the prescription of a medical practitioner, dentist or veterinary surgeon:

1. A-methopterin (4-amino-N10-methylpteroylglutamic acid) and its salts.

2. Amino-an-fol (4-aminopteroylaspartic acid) and its salts.

3. [illegible]

4. Aminopyrine, and any salt, homologue or [illegible]

5. aminopyrine and any salt, homologue or [illegible]

6. Amphetamine, and any salt thereof; and preparations containing amphetamine or any [illegible]

7. Apiol and preparations containing apiol, atropine, and its salts, and liquid preparations containing more than 1/100 gr. per stated dose, or other preparations containing more than 0.1% by weight.

8. Barbituric acid, and any salt, homologue or derivative thereof, and preparations containing barbituric acid or salt, homologue or derivative thereof.

9. Bishydroxycoumarin, its salts and derivatives [illegible]

10. Bisulfan.

11. Bromal and the following derivatives: Bromal hydrate, brometone, bromoform.

12. Carbomycin (magnamycin) and any compound thereof.

13. Carbromal and the following derivates: acetylcarbromal, bromisoval, diethylbromacetamide, allylisopropylacetylurea.

14. Chloral and the following derivatives: alpha-chloralose, chloral-formamide, chloral hydrate, butyl chloral hydrate, chloralimide.

15. Chrloramphenicol (Chloromycetin) and any salt or derivative thereof and preparations containing chloramphenicol or any salt or derivative thereof except where sold for veterinary purposes.

16. Chlorpromazine and its salts.

17. Chloretetracycline (Aureomycin) and any salt or derivative thereof, and preparations containing chlortetracycline or any salt or derivative thereof; except where sold for veterinary purposes.

18. Cinchophen and Neocinchophen and preparations containing cincophen or neocinchophen.

19. Codeine and its salts and their preparations, except preparations containing one-eighth grain or less of codeine per tablet or other solid form, or liquid preparations containing one-third grain or less of codeine per fluid ounce, when such preparations are combined with other medicinal ingredients and the maximum dose

Bromal and the following derivatives: Bromal hydrate, bromotone, bromoform.

Carbomycin (magnamycin) and any compound thereof.

Carbromal and the following derivatives:

[illegible], allylisopropylacetylurea, tamide, allylisopropylacetylurea.

Chloral and the following derivatives: alpha-chloralose, chloral-formamide, chloral hydrate, butyl chloral hydrate, chloralimide.

Chloramphenicol (Chloromycetin) and any salt or derivative thereof and preparations containing chloramphenicol or any salt or derivative thereof except where sold for veterinary purposes.

Chlorpromazine and its salts.

Chlortetracycline (Aureomycin) and any salt derivative thereof, and preparations containing chlortetracycline or any salt or derivative thereof; except where sold for veterinary purposes.

Cinchophen and Neocinchophen and preparations containing cinchophen or neocinchophen.

Codeine and its salts and their preparations, except preparations containing one-eighth grain or less of codeine per tablet or other solid form, or liquid preparations containing one-third grain or less of codeine per fluid ounce, when such preparations are combined with other medicinal ingredients and the maximum dose

prescribed for the preparation contains:

(i) One such ingredient not less in quantity than the amount prescribed by the British Pharmacopoeia as a minimum dose for such ingredient:

(ii) Two such ingredients having similar action, each not less in quantity than one-half the amount prescribed the the British Pharmacopoeia as a minimum dose for each such ingredient respectively; or

(iii) Three such ingredients having a similar action each not less in quantity than one-third that amount prescribed by the British Pharmacopoeia as a minimum dose for each such ingredient respectively.

20. Corticotrophin (ACTH) and preparations containing cortiocotrophin.

21. Cortisone, and any salt or derivative thereof, and preparations containing cortisone or any sale or derivative thereof (including hydrocortisone).

22. Cycloserine.

23. Dihydrostreptomycin and any compound thereof and preparations containing dihydrostreptomycin or any compound thereof except when sold for veterinary purposes.

24. 2:4-dinitrophenol and any compound,

scribed for the preparation contains:

(i) One such ingredient not less in quantity than the amount prescribed by the British Pharmacopoeia as a minimum dose for such ingredient;

(ii) Two such ingredients having similar action, each not less in quantity than one-half the amount prescribed by the British Pharmacopoeia as a minimum dose for each such ingredient respectively; or

(iii) Three such ingredients having a similar action each not less in quantity than one-third the amount prescribed by the British Pharmacopoeia as a minimum dose for each such ingredient respectively.

Corticotrophin (ACTH) and preparations

Cortisone, and any salt or derivative thereof, and preparations containing cortisone or any salt or derivative thereof (including mineocorticoids).

Dihydrostreptomycin and any compound thereof and preparations containing dihydrostreptomycin or any compound thereof except when sold for veterinary purposes.

homologue or derivative thereof.

25. Ergot, and its alkaloids and preparations containing ergot or its alkaloids.

26. Erythromycin and any salt or derivative thereof; and preparations containing erythromycin or any salt or derivative thereof.

27. Fumaglillin.

28. Glutethimide (alpha-ethyl-alpha-phenyl glutaramide) its salts and derivatives.

29. Hydrocyanic. (Prussic) Acid.

30. Hyoscine (Scopolamine) and its salts; and internal preparations and containing more than 1/200 gr. per stated dose, or other preparations containing more than 0.05 per cent by weight.

31. Iproniazid.

32. Isoniazid.

33. Isonicotinic Acid Hydrazide and any derivative thereof; and preparations containing isonicotinic acid hydrozide or any derivative thereof.

34. 6-Mercaptopurine.

35. Methamphetamine, and any salt thereof; and preparations containing methamphetamine or any salt thereof.

36. Novobiocin, its salts and derivatives.

37. Oxytetracycline (Terramycin) and any salt or derivative thereof; and preparations

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TORONTO, ONTARIO

Ergot, and its alkaloids and preparations containing ergot or its alkaloids;

Erythromycin and any salt or derivative thereof; and preparations containing erythromycin or any salt or derivative thereof.

Eumagillin.

Glutaramide) its salts and derivatives.

Hydroxyzamic (Fumaric) Acid.

Hyoscine (Scopolamine) and its salts; and internal preparations and containing more than 1/600 gr. per stated dose, or other preparations containing more than 0.05 per cent by weight.

Ipronidazid.

Iron.

Iron.Citric Acid Hydroxide and any derivative thereof; and preparations containing ironcitric acid hydroxide or any derivative thereof.

Methamphetamine, and any salt thereof; and preparations containing methamphetamine or any salt thereof.

Novobiocin, its salts and derivatives.

Oxytetracycline (Terramycin) and any salt or derivative thereof; and preparations

containing oxytetracycline or any salt or derivative thereof, except where sold for veterinary purposes.

38. Paraldehyde and Metaldenyde.

39. Penicillin, its salts or derivatives and preparations containing penicillin, its salts or derivatives excluding lozenges containing not more than 3000 International Units per dose; except where sold for veterinary purposes.

40. Phenylbutazone and any derivatives thereof; and preparations containing phenylbutazone or any derivatives thereof.

41. Phenylindanedione (Darilone).

42. Phenytoin/Sodium and other Hydantoin derivatives and preparations containing phenytoin-sodium or other hydantoin derivatives.

43. Pipradol Hydrochloride (alpha-a(2-piperidyl) benzhydrol hydrochloride) and its salts.

44. Polymixin ('B' Sulphate), or any preprations thereof except for topical use or for local action in the oral cavity or nasal passage.

45. Primidone.

46. Promazine and its salts.

47. Pyrazinamide (pyrazine-carboxamide).

48. Selenium, and any salt thereof, and preparations containing selenium or any

containing cyclo-[illegible]

salt or derivative thereof, except

[illegible]

Paraldehyde and Metaldehyde.

Penicillin, its salts or derivatives

and preparations containing penicillin,

its salts or derivatives excluding

lozenges containing not more than 3000

[illegible]

where sold for veterinary purposes.

Phenylbutazone and any derivative

[illegible]

phenylbutazone or any derivative

[illegible]

Phenytoin Sodium and other Hydantoin

derivatives and preparations containing

phenytoin-sodium or other hydantoin

[illegible]

benzhydrol hydrochloride) and its salts.

Polymyxin ('B' Sulphate), or any

preparations thereof except for topical

use or for local action in the oral

cavity or nasal passage.

Primidone.

Procaine and its salts.

Pyrazinamide (pyrazine-carboxamide).

Selenium, and any salt thereof, and

preparations containing selenium or any

salt thereof.

49. Sex Hormones as defined by Food and Drug Regulations except skin creams containing sex hormones which are demonstrated to be free from systemic effects.

50. Streptomycin and any compound thereof and preparations containing streptomycin or any compound thereof except where sold for veterinary purposes.

51. Sulphonal and Alkyl Sulphonals.

52. Sulphonamides and any salt, homologue or derivatives thereof and preparations containing sulphonamides or any salt, homologue or derivative thereof; except when sold for veterinary purposes.

53. Tetraethylthiuram disulphide and preparations containing tetraethyl-thiuram disulphide (Disulfiram).

54. Tetracycline (Achromycin) and any salt or derivative thereof, and preparations containing tetracycline or any salt or derivative thereof except where sold for veterinary purposes.

55. Thiocyanates.

56. Thiouracil and any salt, homologue or derivative thereof and preparations containing thiouracil or any salt homologue or derivative thereof.

57. Thyroid and any preparations containing

salt thereof.

Sex Hormones as defined by Food and Drug Regulations except skin creams containing sex hormones which are demonstrated to be free from systemic effects.

Streptomycin and any compound thereof and preparations containing streptomycin or any compound thereof except where sold for veterinary purposes.

Sulphonal and Alkyl Sulphonals.

Sulphonamides and any salt, homologue or derivative thereof and preparations containing sulphonamides or any salt, homologue or derivative thereof, except

Tolbutamidum oleanphide and

Tetracycline (Achromycin) and any salt or derivative thereof, and preparations containing tetracycline or any salt or derivative thereof except where sold

Thiocarbarsa.

Thiouracil and any salt, homologue or derivative thereof and preparations containing thiouracil or any salt, homologue or derivative thereof.

Thyroid and any preparations containing

thyroid.

58. Thyroxin or any salt thereof; and preparations containing thyroxin or any salt thereof.

59. Tretamine.

60. L-Triiodothyronine.

61. Trimethadione or paramethadione or preparations of either of them.

62. Ureides including Bromal or Carbromal and preparations containing ureides.

63. Urethane and any preparations containing urethane.

64. Viomycin and any compound thereof.

Thyroxin or any salt thereof; and preparations containing thyroxin or any salt.

Tranquilizers or parasympatholytics or preparations of either or them.

Uracils including Bromal or Carbromal

Urethane and any preparations

Vinbrydin and any component thereof.

Part II - Schedule A

Articles which may be sold only to a person who in the judgment of the seller is purchasing any of such articles in good faith for its proper use, and after being entered in the Poison Register, and properly labelled:

1. Aconite and alkaloids and preparations thereof; except external preparations containing less than 0.2% acontine.
2. Alkaloids: all poisonous vegetable alkaloids, not specifically mentioned elsewhere in these Schedules and their salts and all poisonous derivatives thereof.
3. Aresenic and preparations and compounds thereof, except as provided in part III of this Schedule.
4. Belladonna and preparations and compounds thereof, except plasters and except as provided in part III of this Schedule.
5. Cantharides and preparations thereof.
6. Carbolic Acid, pure or of greater strength than five per centum when mixed with water, or ten per centum when mixed with glycerin and water, but not crude carbolic acid.
7. Conium and preparations thereof.
8. Croton Oil.
9. Hysocyamus and preparations thereof.
10. Lobelia and alkaloids and preparations thereof except external preparations

Schedule A

who in the judgment of the seller is purchasing any of such articles in good faith for the purpose, and [illegible] labelled:

Aconite and alkaloids and preparations [illegible] containing less than 0.2% aconite.

Alkaloids: all poisonous vegetable [illegible] elsewhere in these Schedules and their salts and all poisonous derivatives thereof.

Arsenic and preparations and compounds thereof, except as provided in part III of this Schedule.

Belladonna and preparations and compounds thereof, except plasters and except as provided in part III of this Schedule.

Cantharides and preparations thereof.

Carbolic Acid, pure or of greater strength than five per cent when mixed with water, or ten per centum when mixed with glycerine and water, but not more particularly [illegible].

Cocine and preparations thereof.

Croton Oil.

Hyoscyamus and preparations thereof.

Lobelia and alkaloids and preparations thereof except external preparations

containing not more than the equivalent of 6 grains of crude lobelia.

11. Mercurial salts, except Calomel, and tablet form of corrosive sublimate, when sold in conformity with the requirements of Food and Drug Act (Canada).

12. Nux Vomica and preparations thereof.

13. Oil of Bitter Almonds, unless deprived of Hydrocyanic (Prussic) Acid.

14. Oil of Rue.

15. Oil of Savin.

16. Oil of Tansy.

17. Potassium Antimonyltartrate (Tartar Emetic).

18. Potassium Cyanide and all other metallic cyanides including cyanogas.

19. Strong solution of lead subacetate (Goulard's Extract).

20. Strophanthus and preparations thereof.

21. Strychnine, its salts and preparations thereof except as provided in Part III of this Schedule.

22. Hohimba and alkaloids thereof and preparations containing yohimba or alkaloids thereof.

tablet form of corrective substance,
when sold in conformity with the
requirements of Food and Drug Act (Canada).

Nux Vomica and preparations thereof.

Oil of Bitter Almonds, unless deprived
of Hydrocyanic (Prussic) Acid.

Oil of Rue.

Oil of Savin.

Oil of Tansy.

Potassium antimonyltartrate (Tartar
Emetic).

Potassium Cyanide and all other metallic
cyanides including cyanogen.

Strong solution of lead subacetate
(Goulard's extract).

Strychnine, its salts and preparations
thereof except as provided in Part I.I
of this Schedule.

Solutions and alcoholic thereof and
preparations containing volatile or
essential oils.

Part III - Schedule A

Articles which may be sold only to a person who in the judgment of the seller is purchasing any of such articles in good faith for its proper use (those marked "#" to be labelled "Poison"):

1. #Acid Chromic.
2. #Acid Oxalic.
3. #Acid Picric (Trinitrophenol).
4. #Amyl Nitrite.
5. #Barium Chloride.
6. #Barium Sulphide.
7. #Benzene (benzol)
8. #Benzene Hexachloride - Lindane, etc. Commexane.
9. #Carbon Bisulphide (Carbon Disulphide).
10. #Carbon tetrachloride - (when labelled as such and where the label bears the skull and crossbones insignia and the following wording: "POISON -- Vapours and odours from this solution are POISONOUS. Use only in open air or well ventilated room: and where the name of the pharmacy in which such sale is made is displayed on the container).
11. #Chlordane.
12. #Chloroform.
13. #Copper carbonate.
14. #Copper subacetate.
15. #Copper sulphate.
16. #Corrosive sublimate, when sold in accordance with legislation of Canada and regulations

Articles which may be sold only to a person

such articles in good faith for its proper use (those

marked "#" to be labelled "Poison"):

1. #Acid Chromic.

#Amy' Nitrite.

#Barium Sulphide.

#Benzene (benzol)

#Benzene Hexachloride - Lindane, etc.

#Carbon Disulphide (Carbon Disulphide).

#Carbon tetrachloride - (Carbon Tetrachloride) as

such and where the label bears the skull and

crossbones indicia and the following wording:

"POISON -- Vapours and odours from this

solution are POISONOUS. Use only in open

air or well ventilated rooms and avoid the

use of the commodity in which such acid is

made is displayed on the container).

#Copper sulphate.

#Corrosive sublimate, when sold in conformity

with legislation of Canada and regulations

thereunder.

17. #Cotton Root and preparations thereof.

19. #Cresol (Cresylic Acid) and its preparations, and the homologues of Cresol and their preparations when stronger than 5% Cresol.

20. #Crude Carbolic Acid.

21. #D.D.T. - 2, 2-bis (p-chlorophenyl) 1,1,1, trichlorocthane.

22. #Derris Root.

24. #Digitalis and preparations thereof.

24. #D.N.O.C. - 3, 5-dinitro-o-cresol, and aly salt thereof.

25. #DNOCHP - 2, 4, dinitro-6-cyclohexylphenol.

26. #Ether.

27. ##thyl Chloride.

28. #Formaldehyde, whether desribed as Formalin or any other trade mark name, mark or designation.

29. #Guaiacol.

30. #Hellebore.

31. #Henna.

32. #Iodine and preparations thereof.

33. #Lead Salts and Solutions.

34. Methoxychlor.

35. #Methyl Hydrate.

36. #Neotran -- (Dow Chem. Co.) --bis (p-chlorophenoxyl) methane.

37. #Oil of Cedar.

38. #Oil of chenopodium.

39. #Oil of Pennroyal.

[illegible] reunder.

17. #Cotton Root and preparations thereof.

18. #Cresol (Cresylic Acid) and its preparations, and the homologues of Cresol and their [illegible]

20. #Crude Carbolic Acid.

[illegible]

#Digitalis and preparations thereof.

#D.N.O.O. - 2, 5-dinitro-o-cresol, and alr salt thereof.

#DIOCHP - 2, 4, dinitro-6-cyclohexylphenol.

[illegible]

#Formaldehyde, whether described as formalin or any other trade mark name, mark or [illegible]

#Guaiacol.

#Hellebore.

#Hemp.

#Iodine and preparation thereof.

#Lead Salts and Solutions.

Methoxychlor.

#Methyl Hydrate.

#Mercury -- (Low Chem. Co.) --bis (p-chlorophenoxyl) methane.

#Oil of Cedar.

[illegible]

#Oil of Pennroyal.

40. #Oil of Wintergreen.

41. #Pennyroyal.

42. #Pest Destroyers of a poisonous nature including:

Arsenate of lead.

H.E.T.P. - hexaethyletraphosphate.

Parathion - O, O diethyl-o-p-nitrophenyl.

Thiophosphate.

Paris Green.

Pestox 3--bis (dimethylaminophosphorous).

Anhydride.

Sodium arsenite including Penite 35.

T.E.P.P. - tetraethylpyrophosphate.

43. #Phosphorus in a free state.

44. #Picrotoxin.

45. #Potassium Bichromate.

46. #Potassium Hydroxide.

47. #Potassium Permanganate.

48. #Rotenone.

49. #Rothane - dichlorodiphenyldichloroethane, including Schradan.

50. #Sabadilla seeds.

51. #Santonin.

52. #Silver Nitrate.

53. #Sodium Fluoride.

54. Sodium Hydroxide.

55. #Stavesacre.

56. #Strammonium and preparations thereof.

57. #Thallium Salts.

58. #Tobacco Extract.

H. . Permyroyal.

Pest Destroyers of a poisonous nature including:

Arsenate of lead.

Paradichlorobenzene - C6H4Cl2 (dichlorobenzene).

Paradox 3--bis (dimethylamino)phosphorous).

Sodium arsenite including Paste 25.

Phosphorous in a free state.

Potassium Dichromate.

Sulfur.

Sodium Hydroxide.

Ammonium and propargyl urea.

59. #Warfarin Compound 42 (WAR42) 3-(d-acetoxylbenzyl) - 4-hydroxycoumarin.

60. Zinc Salts.

61. Arsenic, Belladonna and Strychnine, when combined with other ingredients in preparation of pills, capsules, tablets, elixirs or syrups having medicinal qualities other than those possessed by the drugs named in this clause when taken alone, and in doses not exceeding those of the British Pharmacopoeia and generally recognized as safe medication.

62. Calomel.

63. Chloretone.

64. Ephedrine.

65. Ethinamate.

66. Meprobamate.

67. Methylparafynol.

68. Methyprylon.

69. Nitroglycerin.

70. Nystatin.

71. Quinine and its salts.

72. Penicillin lozenges containing not more than 3,000 International Units per dose.

elixirs or syrups having medicinal qualities other than those possessed by the drugs named in this class when taken alone, or in doses not exceeding those of the British Pharmacopoeia and generally recognized as safe medication.

62. Calomel.

63. Ephedrine.

64. Euphemate.

65. Meprobamate.

66. Methylparaflynol.

67. Methyprylon.

Quinine and its salts.

Pantothilin Ipsen,es containing not more than

SCHEDULE B

Articles which may be sold by any person:

1. Acetylsalicylic Acid (in original packages) whether described as Aspirin, Acetophen, or any other trade name, mark, or designation.
2. Acid muriatic.
3. Acid Sulphuric (Commercial).
4. Alum.
5. Borax.
6. Bicarbonate of Soda.
7. Castor Oil.
8. Cream of Tartar.
9. Carbonate of Soda.
10. Carbonate of magnesia.
11. Chloride of Lime.
12. Di-sodium-Dibrom-Oxymercury-Fluorescein, whether described as "Mercurochrome" or any other trade name, mark or designation.
13. Epsom Salts.
14. Glauber's Salts.
15. Glycerin.
16. Gum Camphor.
17. Hydrogen Peroxide.
18. Impregnated feeding mashes to be used for the prevention control or treatment of poultry and livestock diseases may contain Sulfa Drugs (not more than 0.05%) or antibiotics (up to 500 grams per ton).
19. Phenacetin.
20. Phosphate of Soda.

SCHEDULE B

Articles which may be sold by any person:

[illegible]

[illegible]

[illegible]

[illegible]

Acid Sulphuric (Commercial).

Alum.

[illegible]

Bicarbonate of Soda.

[illegible]

Cream of Tartar.

Carbonate of Soda.

Carbonate of magnesia.

Chloride of Lime

[illegible]

Washer described as "Washerwoman" or any other trade name, mark or designation.

Epsom Salts.

[illegible]

Glycerin.

Iron Sulphate.

[illegible]

Impregnated feeding medes to be used for the prevention, control or abatement of poultry or livestock diseases may contain Sulfa drugs (not more than 0.05%) or antibiotics (up to 500 grams per ton).

Phenacetin.

[illegible]

21. Rhubarb Root.

22. Rochelle Salt.

23. Saltpetre.

24. Senna.

25. Sulphaquinoxaline in either table or concentrated solution to be used for the prevention of Coccidiosis in poultry may be sold in original sealed containers.

26. Sulphur.

27. Solution of Ammonia.

28. Weak Tincture of Iodine (in original bottle).

29. Turpentine.

30. Pest Destroyers of a poisonous nature including:

Arsenate of lead.

H.E.T.P. -- hexaethyltetraphosphate.

Parathion--O, O diethyl-o-p-nitrophenyl thiosphosphate.

Paris Green.

Pestox 3 -- bis (dimethylaminophosphorous) Anhydride.

Dodium arsenite including Penite 35.

T.E.P.P. -- tetraethylpyrophosphate.

Preparations containing less than 10% D.D.T.-- 2, 2-bis (p-chlorophenyl).

1, 1, 1, trichlorocthane.

Warfarin Compound -- 42 (WAFF 42) 3-(d-ace toxylbenzyl) - 4-hydroxycoumarin.

The foregoing only in original containers bearing thereon the manufacturer's label and

sa.tpoces.

Sulphaquinoxaline in either table or concentrated solution to be used for the prevention of Coccidiosis in poultry may be sold in original sealed containers.

Sulphur.

Solution of ammonia.

Weak Tincture of Iodine (in original bottle).

Weak Deactivators of a poisonous nature including.

Arsenate of lead.

Pentox 3 -- bis (dimethylcarbamoyloxyacetamide)

Sodium arsenite including Pentox 35.

Preparations containing less than 10% D.D.T., d, l-cis (p-chlorophenyl).

Warfarin compound -- #2 (WARF #2) 3-(4-nitro oxybenzyl) - 4-hydroxycoumarin.

The foregoing only in original containers bearing thereon the manufacturer's label and

warning.

31. Cresol (Cresylic Acid) and its preparations and the homologues of Cresol and their preparations when weaker than 5% Cresol and sold in original bottles.

32. Formaldehyde.

33. Spirit of Nitre.

34. All articles defined as proprietary or patent medicines by any Statute of Canada.

35. Any other article not listed in Schedule A.

Cresol (Cresylic Acid) and its preparations and the homologues of Cresol and their preparations when weaker than 5% Cresol and acid in original bottles.

Formaldehyde.

All articles defined as proprietary or patent medicines by any Statute of Canada.

Any other article not listed in Schedule A.

B

Appendix B
To Submission By The
New Brunswick
Pharmaceutical Society

SUMMARY OF PROVISIONS OF THE

NARCOTIC CONTROL ACT

P. C. 1961 - 1133

The New Brunswick Pharmaceutical Society is subject to the provisions of the Narcotic Control Act, P.C. 1961-1133 and the following is a summary of the relevant sections of this Act.

1-B (Sec. 23)

A pharmacist, upon receipt of a narcotic from a licensed dealer or from another pharmacist as provided in Section 36 shall forthwith enter in a book, register or other record maintained for such purposes, the following:

(a) The name and quantity of the narcotic received.

(b) The date the narcotic was received, and,

(c) The name and address of the person from whom the narcotic was received.

2-B (Sec. 24)

No pharmacist shall, except as provided in sections 25, 26 and 27 supply a narcotic to any person unless he has first received a written order or prescription therefor signed and dated by a practitioner and the signature of the practitioner where not known to the pharmacist has been verified by him.

Appendix "B"
To Submission By The

NARCOTIC CONTROL ACT

R. S. 1961 - 1123

The New Brunswick Pharmaceutical Society is subject to the provisions of the Narcotic Control Act, R.S. 1961-1123 and the following is a summary of the relevant sections of this Act.

A pharmacist, upon receipt of a narcotic from a licensed dealer or from another pharmacist as provided in Section 36 shall forthwith enter in a book, register or other record maintained for such purposes, the following:

(a) The name and quantity of the narcotic received.

(b) The date the narcotic was received, and,

(c) The name and address of the person from whom the narcotic was received.

2-F (Sec. 24)

No pharmacist shall, except as provided in sections 25, 26 and 27 supply a narcotic to any person unless he has first received a written order or prescription therefor signed and dated by a practitioner and the signature of the practitioner where not known to the pharmacist has been verified by him.

3-B (Sec.25)

Subject to Section 30, a pharmacist may dispense an oral prescription narcotic upon prescription or order given verbally by a practitioner provided he has taken reasonable precautions to satisfy himself that the person giving the prescription or order is a practitioner.

4-B (Sec.26)

A pharmacist may supply a narcotic to a hospital upon a written order from:

(a) The pharmacist in charge of the dispensary of the hospital, or,

(b) A practitioner authorized by the hospital to sign the order on its behalf.

5-B (Sec.27)

A pharmacist may, with a prescription, sell a preparation containing one-eighth grain or less or its equivalent of Codeine Phosphate per tablet or in any othe solid form or one-third grain or less of its equivalent of Codeine Phosphate per fluid ounce in liquid preparations, if:

(a) The Codeine Phosphate in such preparation is combined with medicinal ingredients other than narcotics and the minimum doses recommended for the preparation contains:

(i) one such medicinal ingredient other than the

[illegible]

[illegible]

[illegible]

Codeine Phosphate not less in quantity than the recognized minimum single dose for such ingredients.

(ii) Two such medicinal ingredients having a similar action other than the Codeine Phosphate if each is not less in quantity than one-half the recognized minimum single dose for each such ingredients, or,

(iii) Three such ingredients having a similar action other than the Codeine Phosphate if each is not less in quantity than one-third the recognized minimum single dose for each such ingredients; and,

(b) There is legibly and conspicuously printed on the main panel of the label and on any outer container the full formula or true list of all active ingredients and a caution to the following effect- "This preparation contains Codeine and should not be administered to children except on the advice of a physician".

A pharmacist shall not use an order or prescription, written or verbal, to dispense a narcotic on more than one occasion.

7-B (Sec.29)

A pharmacist shall forthwith after dispensing

Codeine Phosphate not less in quantity than the recognized minimum single dose for such

(ii) Two such medicinal ingredients having a similar action other than the Codeine Phosphate if each is not less in quantity than one-half the recognized minimum single dose for each such ingredients; or,

(iii) Three such ingredients having a similar action other than the Codeine Phosphate if each is not less in quantity than one-third the recognized minimum single dose for each such ingredients; and,

(b) There is legibly and conspicuously printed on the main panel of the label and on any other container the full formula or name list of all active ingredients and a caution to the effect "This preparation contains Codeine and should not be administered to children except on the advice of a physician".

A pharmacist shall not use an order or prescription, written or verbal, to dispense a narcotic on more than one occasion.

T-E (Sec.29)

a narcotic, other than an oral prescription narcotic, pursuant to a written order or prescription, enter in a book, register or other record maintained for such purposes:

(a) The name and address of the person named in the order or prescription.

(b) The name, quantity and form of the narcotic.

(c) The name, initials and address of the practitioner who issued the order or prescription.

(d) The name or initials of the pharmacist who supplied the narcotics.

(e) The date the narcotic was supplied, and,

(f) The number assigned to the order or prescription.

8-B (Sec.30)

A pharmacist shall, before dispensing an oral prescription narcotic pursuant to an order or prescription verbally given therefor, make a written record thereof, setting forth:

(a) The name and address of the person named therein.

(b) In accordance with the manner in which it is specified in the prescription, the name and quantity of such oral prescription narcotic or the narcotic and the other medicinal ingredients therein.

(c) The directions for use therewith.

book, register or other record maintained for such purposes:

(a) The name and address of the person named in the order or prescription.

(b) The name, quantity and form of the narcotic.

(c) The name, initials and address of the practitioner who issued the order or prescription.

(d) The name or initials of the pharmacist who supplied the narcotics.

(e) The date the narcotic was supplied, and

(f) The number assigned to the order or prescription.

S-B (Sec.30)

A pharmacist shall, before dispensing an oral prescription narcotic pursuant to an order or prescription verbally given therefor, make a written record thereof, setting forth:

(a) The name and address of the person named therein.

(b) In accordance with the manner in which it is specified in the prescription, the name and quantity of such oral prescription narcotic or the narcotic and the other medicinal ingredients.

(c) The directions for use thereunto.

(d) The name and initials of the practitioner who issued the order or prescription.

(e) The name or initials of the pharmacist who dispensed such oral prescription narcotic.

(f) The date such oral prescription narcotic was supplied, and,

(g) The number assigned to the order or prescription.

9-B (Sec.31)

(1) A pharmacist shall maintain a special narcotic prescription file in which shall be filed in sequence as to date and number and written record of all oral prescription narcotics dispensed pursuant to an order or prescription verbally given as provided in Section 30.

(2) A pharmacist shall retain in his possession for a period of at least two years any records which he is required to keep by these Regulations.

10-B (Sec.32)

A pharmacist shall:

(a) Furnish such information respecting the dealings of the pharmacist in any narcotic such form and at such times as the Minister may require.

(b) Make available and produce to an inspector upon request his special narcotic prescription file together with any books, records or documents which he is required to

prescribed by the order or

(e) The name or initials of the pharmacist who dispensed such drug,

(f) The date such drug prescription was supplied, and,

(g) The number assigned to the order.

narcotic prescription file in which shall be filed in sequence as to date and number and written record of all such prescriptions narcotics dispensed pursuant to an order or prescription verbally given as provided in section 10.

(2) A pharmacist shall retain in his possession for a period of at least two years any records which he is required to keep by these Regulations.

A pharmacist shall:

(a) Furnish such information respecting the holdings of the pharmacist in any narcotic drug as at such times as the Minister may

(b) Make available for inspection upon request the special narcotic prescription file number with any other

keep.

(c) Permit an inspector to make copies of or to take extracts from such files, books, records or documents, and,

(d) Permit an inspector to check all stocks of narcotics on his premises.

11-B (Sec.33)

A pharmacist shall report to the Minister any loss or theft of a narcotic within ten days of his discovery thereof.

12-B (Sec.34)

A pharmacist shall keep all narcotics except oral prescription narcotics securely in a locked receptacle, drawer or safe.

13-B (Sec.35)

(1) No pharmacist shall prepare a narcotic unless the Minister has approved the formula thereof, and if such narcotic is a preparation described in Section 27, has approved the label and the size of the container in which it will be sold.

(2) A pharmacist who prepars a narcotic shall, in addition to all other records required to be kept, keep a record of the following:

(a) The kind and quantity of any narcotic used in the preparation.

(b) The name and quantity of the narcotic prepared, and,

(c) The date that the prepared narcotic was placed in stock.

(3) For the purposes of this section, "Prepare

[illegible]

(c) [illegible]

[illegible]

records or documents; and

(d) Permit an inspector to check will stocks of narcotics on hand[illegible].

11-B (Sec.34)

A pharmacist shall report to the Minister any loss or theft of a narcotic within ten days of his dis-[illegible]

12-B (Sec.34)

A pharmacist shall keep all narcotics except oral prescription narcotics securely in a locked receptacle, drawer or safe.

13-B (Sec.35)

(1) No pharmacist shall prepare a narcotic unless the Minister has approved the formula thereof, and if such narcotic is a preparation described in Section 27, has approved the label and the size of the container in which it will be sold.

(2) A pharmacist who prepares a narcotic shall, in addition to all other records required to be kept, keep a record of the following:

(a) The kind and quantity of any narcotic used in the preparation.

(b) The name and quantity of the narcotic [illegible]

[illegible]

(c) The date that the prepared narcotic [illegible]

(3) For the purposes of this section, "prepare

does not include the compounding of a narcotic pursuant to a prescription of a practitioner.

14-B (Sec.36)

(1) Upon receiving a written order, a pharmacist may supply a narcotic to a licensed dealer or other pharmacist and shall forthwith notify the Minister setting out the details thereof.

(2) A pharmacist shall forthwith after removing, transporting or transferring a narcotic from his place of business to any other place of business operated by him, notify the Minister setting out the details thereof.

15-B (Sec.37)

Where, in the opinion of the Minister, it is necessary to do so for the proper administration and enforcement of the Act or these Regulations, the Minister may refer to the appropriate provincial licensing authority of any province in which a pharmacist is registered and licensed any information obtained under these Regulations together with any other information he considers relevant, and the following consultation with such provincial licensing authority may, notwithstanding anything contained in these Regulations, impose such conditions as in his opinion may be desirable in the public interest on the right of such pharmacist to purchase a narcotic.

16-B

Definitions as applicable under this Act are to be found in the Regulations respecting the Control of Narcotics.

not include the compounding of a narcotic pursuant to a prescription of a practitioner.

14-B (Sec.36)

(1) Upon receiving a written order, a pharmacist may supply a narcotic to a licensed doctor or other pharmacist and shall forthwith notify the Minister [illegible]

(2) A pharmacist shall forthwith after removing, transporting or transferring a narcotic from his place of business to any other place of business operated by him, notify the Minister setting out the details thereof.

15-B (Sec.37)

Where, in the opinion of the Minister, it is necessary to do so for the proper administration and enforcement of the Act or these Regulations, the Minister may refer to the appropriate provincial licensing authority of any province in which a pharmacist is registered and licensed any information obtained under these Regulations together with any other information he considers relevant, and the following consultation with each provincial licensing authority may, notwithstanding anything contained in these Regulations, impose such conditions as in his opinion may be desirable in the public interest as the right of such pharmacist to purchase a narcotic.

16-B

Definitions as applicable under this Act are to be found in the Regulations respecting the Control of Narcotics.

C

Appendix C
To Submission By The
New Brunswick
Pharmaceutical Society

SUMMARY OF PROVISIONS OF THE

FOOD AND DRUGS ACT

CHAPTER 38 OF THE STATUTES OF CANADA 1953

WITH AMENDMENTS TO AUGUST 9, 1961

1-C This Act has to do with advertising and making of claims regarding certain products, it spells out in detail what may not be advertised and more particularly it mentions specific diseases for which no person shall advertise any food, drug, cosmetic or device to the general public as a treatment, preventative or cure for any of the diseases, disorders or abnormal physical states mentioned in Schedule A.

2-C No person shall sell any drug that:

(a) Was manufactured, prepared, preservied, packed or stored under unsanitary conditions or

(b) Is adulterated.

No person shall sell or distribute any drug referred to in Schedule F without an oral or written prescription from a medical practitioner, dentist or veterinary surgeon. For all practical purposes Schedule F may be considered the same schedule as the Schedule A Part 1 of the New Brunswick Pharmaceutical Act.

3-C On the 15th of September 1961 amendment P.C. 1961-1132 to this Act was effective and in brief this amendment was to set up a new Schedule G. This schedule

To Superseded By The
New Summaries

SUMMARY OF PROVISIONS OF THE

FOOD AND DRUGS ACT

CHAPTER 38 OF THE STATUTES OF CANADA 1953

WITH AMENDMENTS TO AUGUST 9, 1961

1-C This Act has to do with advertising and making of claims regarding certain products. It applies - in detail what may not be advertised and more specifically in mentions specific diseases for which no person may advertise any food, drug, cosmetic or device to the general public as a treatment, preventative or cure for any of the diseases, disorders or abnormal physical states mentioned in Schedule A.

2-C No person shall sell any drug that:

unsanitary conditions or

(c) Is adulterated.

No person shall sell or distribute any drug referred to in Schedule F without an oral or written prescription from a medical practitioner, dentist or veterinary surgeon. For all practical purposes a drug F may be considered the same as listed on the Schedule A Part I of the New Zealand Pharmaceutical Act.

3-C On the 15th of September 1961 amendment P.C. 1961-1132 to this Act was effective and by virtue of this amendment was to set up a new Schedule. This schedule

includes:

(1) Amphetamine and its salt.

(2) Barbituric acid and its salts and derivatives.

(3) Methamphetamine and its salt.

For all practical purposes these may be considered as narcotics, in that they must be signed for by the pharmacist, they must be entered in a book, and inventory must be kept at all times and upon sale they be again entered noting the person's name, the prescribing doctor etc. The enforcement of these regulations comes under the Narcotic inspectors, so they may be kept on the same file as a 11 narcotic prescriptions.

4-C

SCHEDULE "A"

Alcoholism

Appendicitis

Arterioscierosis

Blood Poisoning

Bright's Disease

Cancer

Diabetes

Diptheria

Disorders of menstrual flow

Disorders of the prostatic gland

Dropsy

Epilepsy

Erysipelas

Gallstones, Kidney Stones, Bladder Stones

Gangrene

Goitre

includes:

(1) Amphetamine and its salt.

(2) Barbituric acid and its salts and derivatives.

(3) Methamphetamine and its salt.

For all practical purposes these may be considered as narcotics, in that they must be signed for by the pharmacist, they must be entered in a book, and inventory must be kept at all times and upon sale they be again entered noting the person's name, the prescribing doctor etc. The enforcement of these regulations comes under the Narcotic Inspectors, so they may be kept on the same file as a 11 narcotic prescriptions.

4.0 SCHEDULE "A"

Alcoholism

Appendicitis

Blood Poisoning

Bright's Disease

Cancer

Diphtheria

Diseases of the prostatic gland

Dropsy

Dysentery

Dysipelas

1 Heart Diseases
2 High Blood Pressure
3 Infantile Paralysis
4 Influenza
5 Lockjaw
6 Locomotor Ataxia
7 Obesity
8 Pleurisy
9 Pneumonia
10 Ruptures
11 Scarlet Fever
12 Sexual Impotence
13 Small Pox
14 Spinal Meningitis
15 Trachoma
16 Tuberculosis
17 Tumors
18 Typhoid Fever
19 Ulcers of the gastro-intestinal tract.
20 Venereal Diseases
21
22
23
24
25
26
27
28
29
30

D

Appendix D
To Submission By The
New Brunswick
Pharmaceutical Society

DEFINITIONS

1. "CERTIFIED CLERK" means a person registered as such under the provisions of the New Brunswick Pharmaceutical Act 1958.

2. "DRUG" means any substance,

(i) that is named in the latest edition from time to time of the British Pharmacopoeia, British Pharmaceutical Codex, Pharmacopoeia of the United States of America, National Formulary New and Nonofficial Remedies, Canadian Formulary, Codex Francais, Pharmacopoeia Internationalis or any other Pharmacopoeia approved and accepted by the Department of National Health and Welfare of Canada, and,

(ii) that is offered for sale or sold for the prevention or treatment of any ailment but does not include any such substance or preparation offered for sale or sold as, or as part of, a food, drink or cosmetic or for any purpose other than the prevention or treatment of any ailment, disease or physical disorder.

3. "MEDICINE" includes all drugs for internal or external use of man or animal and any substance or mixture of substance intended to be used for the treatment, medication or prevention of disease or pain in man or

Appendix D
To Submission By The
New Brunswick

DEFINITIONS

1. "DISPENSING OFFICER" means a person registered as such under the provisions of the New Brunswick Pharmaceutical Act 1958.

2. "DRUG" means any substance,

(i) that is named in the latest edition from time to time of the British Pharmacopoeia, of the United States of America, National Formulary New and Nonofficial Remedies, Pharmacopoeia International or any other Pharmacopoeia approved and accepted by the Department of National Health and Welfare of Canada, and,

(ii) that is offered for sale or sold for the prevention or treatment of any ailment but does not include any such substance or preparation offered for sale or sold as, or as part of, a food, drink or cosmetic or for any purpose other than the prevention or treatment of any ailment, disease or physical disorder,

or external use of man or animal and any substance or mixture of substance intended to be used for the treatment medication or prevention of disease or pain in man or

animal.

4. "PRESCRIPTION" means a formula or direction given by a legally qualified medical practitioner, dentist or veterinary surgeon for, a remedy for, or treatment for, a disease or disorder, prescribing the ingredients with or without the method of using.

5. "RETAIL PHARMACY" means a shop or place of business where poisons, drugs or medicines are sold or exposed for sale to the general public.

6. "DISPENSING OF MEDICINES" means the issuance of any multiple dose container to the patient.

7. "ADMINISTERING OF MEDICINES" covers the issuance of a single dosage from a stock container.

8. "PHARMACY" is that profession which is concerned with the art and science of preparing from natural and synthetic sources, suitable and convenient materials for distribution and use in the diagnosis, treatment and prevention of disease. It embraces a knowledge of the identification, selection, pharmacological action, preservation, combination, analysis, and standardization of drugs and medicines. It also includes their proper and safe distribution and use whether dispensed on the prescription of a licensed physician, dentist, or veterinarian or, in those instances where it may legally be done, dispensed or otherwise made available to the consumer.

9. "PHARMACIST" is one who, through academic qualification and legal professional registration, is responsible for the preparation and distribution of the dosage forms of drugs. The pharmacist practises his

4. "PRESCRIPTION" means a formula or direction given by a legally qualified medical practitioner, dentist or veterinary surgeon for, a remedy for, or treatment for, a disease or disorder, prescribing the ingredients with or without the method of using.

5. "RETAIL PHARMACY" means a shop or place of business where potions, drugs or medicines are sold or exposed for sale to the general public.

6. "DISPENSING OF MEDICINES" means the issuance of any multiple dose container to the patient.

7. "ADMINISTERING OF MEDICINES" covers the issuance of a single dosage from a stock container.

8. "PHARMACY" is that profession which is concerned with the art and science of preparing from natural and synthetic sources, suitable and standard materials for distribution and use in the diagnosis, treatment and prevention of disease. It embraces a knowledge of the identification, selection, pharmacologi standardization of drugs and medicines. It also involves their proper use, safe distribution and use whether prepared on the prescription of a licensed physician, dentist, or veterinarian or, in those instances where it may legally be done, dispensed or otherwise made available to the consumer.

9. "PHARMACIST" is one who, through academic qualification and legal professional registration, is

profession through the compounding and dispensing of medical prescriptions, and through the comprehension and dissemination of information related to the science which embraces all knowledge of drugs, their identification, mechanism of action, toxicity, therapeutic activity, palatability, stability, dosage form, potentiality with other drugs and synergism in combination, and includes the standardization and critical evaluation of medicinal agents and pharmaceutical preparations. The pharmacist's duties include general supervisory control combined with certain specific legal responsibilities relative to certain drugs, in addition to direct obligations concerning the purchase, storage, and safeguarding and distribution of drugs, in bulk chemical state or finished pharmaceutical form, whether such duties pertain to advisory, technical or administrative functions or to his occupation as a pharmacy practitioner.

preparation through the compounding and dispensing of

examination of information related to the science which embraces all knowledge of drugs, their identification,

other drugs and synergism in combination, and includes the standardization and critical evaluation of such that

duties include general supervisory control combined with certain specific legal responsibilities relative to control drugs, in addition to direct obligations governing the purchase, storage, and sale/sending and distribution of drugs, in bulk chemical state or finished pharmaceutical form, whether such duties pertain to advisory, managerial or administrative functions or to his competence as a

E

Appendix E
To Submission By The
New Brunswick
Pharmaceutical Society

PART (1)

STATISTICS TO ARRIVE AT

PRESCRIPTION DOLLAR VOLUME

THROUGH RETAIL OUTLETS IN NEW BRUNSWICK

Methods of estimating total retail drug store prescription volume in New Brunswick in year 1960.

(A) Based on an estimated per capital drug cost.

$7.50 (a) x 606,000 (b) - $4,545,000

(B) Based on per capita prescription expenses as adjusted.

$9.00 (c) x 606,000 (b) - $5,454,000

(C) Based on survey of New Brunswick retail pharmacies.

This is a projected figure based on returns from 38% of the retail pharmacies in New Brunswick and is subject to adjustment when final returns are available.

(a) Per capita prescription costs based on 19th Annual C.Ph.A. Survey (1960).

(b) Province of New Brunswick population used throughout for calculations per D.B.S. February, 1961.

(c) D.B.S. "City Family Expenditures, 1957" adjusted to reflect increase in price index of drugs from 1957 to 1960.

Appendix F
To Submission By The
New Brunswick
Pharmaceutical Goals

[illegible]

[illegible]

[illegible]

F

Appendix F
To Submission By The
New Brunswick
Pharmaceutical Society

THE APOTHECARY

VOL. 73 - AUGUST 1961 - NO.8

ARTICLE BY DR. EDWARD FITZGERALD

Dispensing Physicians.

A prominent Kansas physician Dr. Edward L. Fitzgerald, Hutchison, speaks out on physicians owning and profiting on prescription business.

Dr. Fitzgerald makes ten specific points which leave no doubt as to his opinion as regards the pharmacists' responsibility and privilege in the dispensing of drugs; the storing, packaging, labelling, refrigerating, replacing for freshness, etc.

Dr. Fitzgerald further upholds the right of the public to free choice of pharmacist as well as free choice of physician and hospital. He declares that the American Way of Life, which is the way of the private enterprise -- profit -- system, is the best way of life for United States citizens.

Here are ten points of Dr. Fitzgerald's letter:

(1) For years the American Medical Association considered it unethical and not in the interest of the public for a physician to profit directly or indirectly on the medication dispensed on his own prescriptions.

(2) The unfortunate patient should not

Exhibit 1
To Submission By The
New Brunswick
Pharmaceutical Society

[illegible] 13 - AUGUST 1951 - No. 3

ARTICLE BY DR. EDWARD FITZGERALD

Dispensing Physicians.

A prominent Kansas physician Dr. Edward L. Fitzgerald, Hutchinson, speaks out on physicians owning and profiting on prescription business.

Dr. Fitzgerald makes ten specific points which leave no doubt as to his opinion as regards the pharmacists' responsibility and privilege in the dispensing of drugs; the storing, packaging, labelling, [illegible], etc.

Dr. Fitzgerald further upholds the right of the public to free choice of pharmacist as well as free choice of physician and hospital. He declares that the American way of life, which is the way of the private enterprise -- profit -- system, is the best way of life for United States citizens.

Here are ten points of Dr. Fitzgerald's [illegible]

(1) For years the American Medical Association considered it unethical and not in the interest of the public for a physician to profit directly or indirectly on the medication dispensed on his [illegible]

(2) The unfortunate patient should not

be placed in a middle position, where on one end the physician collects medical fees, and on the other end the physician collects a profit on the drugs he prescribes.

(3) When pharmacies are financially divorced from the prescribing physician, the physician is genuinely interested in how little and how economically he can prescribe for his patient. When the reverse is true, the physician is tempted on how much he can prescribe and how much longer he can keep his patient on his profit making medications.

(4) In practice the physician-owned pharmacies destroy the patient's freedom of choice of pharmacies and circumvents the competitive advantages it offers.

(5) Certainly the divided interest of pharmacies from physicians has acted as a check and balance pattern which has become an American heritage. In a larger measure this has helped to keep each profession honorable without public accusation of merchandising medicine on the American Public.

(6) The public would not tolerate for General Motors to own our filling stations or the electric power companies having a corner on the electric appliances. Federal laws are restrictive and demand that a private pharmacy cannot dispense, sell, give away or even consume his own stock of prescription legend drugs. Private pharmacies only avenue for dispensing his prescription legend drug stock is on a bona fide physician's prescription. When we allow physicians to put in their own pharmacies, which usually get his

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prescription trade either by direction or designed convenience, the private pharmacy is helpless to dispense his prescription legend drugs, which is about 90% of his prescritpion stock.

(7) Several years ago the Justice Department broke up an arrangement in which physicians were getting a profit on the spectacles they prescribed, via a "kickback" from the optical companies. As I recall, in addition to a heavy fine, an order was issued to "forever cease and desist this practice." Perhaps this order covers the current problem and trend in which a minority of physicians are engaged with respect to profiting on prescriptions.

(8) The public demands and industry accepts, controls to avoid monopolies in business; since physicians and pharmacists are dealing in matters of health, illness and life itself, it seems even more important that we do not permit arrangements that lend themselves to monopolies on a defenseless and uninformed public.

(9) In isolated rural areas there are occasions in which a physician has to personally dispense his own drugs in the absence of a private pharmacy in the area. However, this should not be confused with the practice of physicians forming clinics and installing their own pharmacy to dispense their wares through what appears to be an innocent private pharmacy but actually is owned by the physicians. This is being done in the presence of a number of private pharmacies competing in the immediate area.

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(10) If physicians are allowed to become profit seeking businessmen, then the profession of the physician and the profession of the pharmacist will both decay, and the public will suffer the loss.

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I would like to answer any questions.

THE CHAIRMAN: You are suggesting, Mr. Townsend, referring to Clause 3 in your summary, that all hospitals over 30 beds - that would be a hospital of 31, 40 beds?

MR. TOWNSEND: Yes. This number was more or less picked at random where we thought a pharmacist would be utilized.

THE CHAIRMAN: Do you suggest that there would be full-time employment for a pharmacist in a hospital of 40 beds?

MR. TOWNSEND: I think if the pharmacist was given the purchasing of drugs and purchasing of drug supplies - and I believe that the pharmacist is the man most capable of doing this job, sir - then it would be a full-time job.

THE CHAIRMAN: He would have to have other duties.

MR. TOWNSEND: Oh, definitely, yes. I believe that is set out in Section 12(D).

THE CHAIRMAN: What do you mean by that recommendation 4, Clause 10, the second page: "Freedom of the pharmacist to conduct all or any part of his professional practice outside of any health care program if he so chooses"?

MR. TOWNSEND: Frankly, my lord, what has happened in England and other countries who have gone on a national health scheme, they found in addition to this there must be payment of prescriptions, and we didn't want to restrict ourselves to only a national health

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THE CHAIRMAN: You are suggesting, Mr. Townsend, referring to Clause 3 in your summary, that all [illegible] be [illegible]

MR. TOWNSEND: Yes. This number was more [illegible]

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MR. TOWNSEND: Frankly, my lord, what has happened in Ontario [illegible] there must be payment of prescriptions, and we didn't want to restrict ourselves to only a national health

scheme.

THE CHAIRMAN: But supposing you do have a comprehensive health services program, what are the other areas in which a pharmacist might practise his profession if he so chooses? I just want to understand what your recommendation is.

MR. TOWNSEND: I believe this is more of a long-term project. We see deterrent use of drugs restricted in national health in other countries. For instance, a new drug comes on the market. A physician might want to prescribe it, but it is not on the list of drugs, then the pharmacist could stock this drug and the patient could pay for it, and this is basically what we mean.

THE CHAIRMAN: In No. 8 you suggest that if there is any comprehensive program, because it is inherent in the nature of the public, as you say, as a whole, to use to excess services which are apparently provided free, and so forth. By that do you go so far as to support the idea of a charge on each prescription, either what might be called a deterrent charge or an initial charge, either the English system or the Australian system?

MR. TOWNSEND: We would like to have further study with regard to this deterrent clause. We think there should be a deterrent, but we don't know what it should be as yet.

THE CHAIRMAN: You wish to make a further submission on that?

MR. TOWNSEND: Yes, sir.

THE CHAIRMAN: But supposing you do have a comprehensive health services program, surely the great amount of financial aids [illegible] and provisions [illegible] I just want to understand more [illegible] it.

MR. TOWNSEND: I believe this is more of a long-term project. We see deterrent use of drugs restricted in national health in other countries. For instance, a new drug comes on the market. A physician might want to prescribe it, but it is not on the list of [illegible], then the [illegible] would have [illegible] patient could pay for it, and this is basically what we want.

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MR. TOWNSEND: Yes, sir.

THE CHAIRMAN: May I ask you, No. 4, regarding the problem of the dispensing physician. Now, you are not going all the way that if a physician carries drugs for immediate use ---

MR. TOWNSEND: No, naturally not. We are taking the position of setting up a dispensary.

THE CHAIRMAN: How prevalent is that situation?

MR. TOWNSEND: In this area I am happy to say it is non-existent, but in the northern part of our Province it does exist to some degree, and we feel it is quite unfair competition.

THE CHAIRMAN: In those areas are there also pharmacies available?

MR. TOWNSEND: Yes, well-staffed pharmacies.

COMMISSIONER GIRARD: Mr. Townsend, with regard to the hospital pharmacist's stocks, would you consider the stocking of supplies as one of the functions of the pharmacist?

MR. TOWNSEND: I am not a hospital pharmacist myself, and it is rather hard to answer that question. I think it could be done without too much of a problem, but not being a hospital pharmacist and not having really the detailed knowledge of a hospital I would have to hedge my answer, quite frankly.

COMMISSIONER GIRARD: I ask this question because it is being done more and more, and some people consider this a function of the hospital pharmacist. I wanted to know your opinion on this. Thank you.

COMMISSIONER VAN WART: Page 7, Summation

THE CHAIRMAN: May I ask you, No. 4,

[illegible] the practice of the Associated Hospitals, Mr. [illegible] you [illegible] all the way back if a pharmacist [illegible] from hospitals has --

MR. TOWNSEND: No, naturally not. We are having the problem of working up a dispensary.

THE CHAIRMAN: How prevalent is that situation?

MR. TOWNSEND: In this area I am happy to say it is non-existent, but in the northern part of our province it does exist to some degree, and we feel it is quite under [illegible].

THE CHAIRMAN: In those areas are there also pharmacies available?

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[illegible]

No. 15, the second paragraph, you state that you would ask the Government to consider the continuance of the present system of distribution, and so on, and you go on and state in the next page that "It is felt that any National Health Service will cost the Government a good deal more money than the distribution at the present time". I take from that that you are in favour of the competitive aspect of drugs, that is to say, with many outlets in competition with one another, rather than have one outlet for drugs?

MR. TOWNSEND: You are referring there to a retail outlet?

COMMISSIONER VAN WART: Retail outlets, yes.

MR. TOWNSEND: Oh, yes, I am in favour of competition.

COMMISSIONER VAN WART: And you visualize that in a government benefit scheme you would not have that same competition present?

MR. TOWNSEND: I wouldn't necessarily say that.

COMMISSIONER VAN WART: Do you visualize then several outlets under a benefit scheme?

MR. TOWNSEND: Oh, yes, sir, I could visualize ----

COMMISSIONER VAN WART: Several retail outlets?

MR. TOWNSEND: Yes.

COMMISSIONER VAN WART: And you would then, having that, you say there would be more expense, it would cost the country a great deal more money than the distribution at the present time. Now, why is that?

MR. TOWNSEND: We feel what we call utilization rate, if we can come back to this, here in our province, and I emphasize on the preliminary survey only, runs approximately 2.5, slightly over. In New Zealand, they went from there in ten years to a use rate of 5. I can give you the reference right here if you so desire. If you take an average of $3.00 per prescription,

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you can well see what it would cost New Brunswick for drugs if the utilization was five instead of just half that, which is twice as much money for drugs.

COMMISSIONER VAN WART: You would attribute the over-utilization to a benefit scheme, in other words?

MR. TOWNSEND: I am not too sure if this over-utilization is the correct word, Dr. Van Wart. I am not quite certain in my own mind that there are not areas here that perhaps people just don't get the drugs, and I have no facts or figures to prove this, but as I say, I am uncertain of this, and therefore, if we take this to be a standard at 2.5 we might be assuming something erroneous. It might be that we might be paying for three or four, but I am afraid I cannot answer that at the present time.

COMMISSIONER VAN WART: The point I want to make is that if you have a benefit scheme in effect, more people would be receiving attention that didn't receive it before, and that would run your costs up, and that is not from over-utilization, that is just more utilization by virtue of a scheme that is available to be used by the public. But you still maintain that the competitive form of retailing is the best type of retailing?

MR. TOWNSEND: Yes, I can visualize the competitive form of retailing under national health, where as we say in our summary there that the patient has the choice of the pharmacist, we would have probably the same number of drug stores in Fredericton, for

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instance, as we have today, each of us competing for that patient's prescription, and competing on a service basis, and I think that it would be the same, except that the government would be paying the bill.

COMMISSIONER VAN WART: I notice one of your recommendations is that a pharmacist should be represented on any body charged with the development and administration of policies pertaining to pharmaceutical services. Your organization is quite insistent upon that, are you?

MR. TOWNSEND: Definitely, sir.

COMMISSIONER VAN WART: And you are also insistent that if any scheme comes in, that the pharmacist shall have the right to carry on a private practice outside of this scheme?

MR. TOWNSEND: Yes, sir.

COMMISSIONER FIRESTONE: Mr. Chairman, my first question is addressed to Mr. Townsend. Would your association be in favour of a prepaid system of providing comprehensive drug coverage for the people of the Province of New Brunswick?

MR. TOWNSEND: Yes, we would, if we could afford it. Well, I don't mean to be facetious there, sir, we feel that the cost is going to be very very high, and should be looked into very carefully, but nothing in our basic philosophy, in our basic thinking, precludes a national health scheme.

COMMISSIONER FIRESTONE: Can you explain to the Commission a little what you mean, if we can afford it? What did you have in mind?

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Sir, we feel that the cost is going to be very very high, and should be looked into very carefully, but nothing in our basic philosophy, in our basic thinking precludes a national health scheme.

COMMISSIONER PIERCE: Can you explain to the Commission a little what you mean, if we can afford it? What did you have in mind?

MR. TOWNSEND: Well, sir, again I feel that a scheme would cost New Brunswick in the vicinity of thirty to forty millions of dollars. Now, in 1959 the individual taxpayer in New Brunswick paid to the Federal Government twenty-two millions of dollars. This means that we have to raise quite an additional amount of revenue. This is the individual, sir. There is no corporation in it.

COMMISSIONER FIRESTONE: If I may continue with the questioning, Mr. Townsend. I am just wondering what happens in a case where a doctor says to a patient: "My dear man, you are ill and you need that particular drug". Can that person afford not to buy the drug?

MR. TOWNSEND: No, sir.

COMMISSIONER FIRESTONE: Fine sir. Now, he may not have the money to buy the drug. What will happen in a case like that?

MR. TOWNSEND: I think in a case like that, sir, there are welfare organizations and things like that. I think that also quite frankly that there is a lot of charges on a retail pharmacist's books that prove this to be correct.

COMMISSIONER FIRESTONE: In other words, what you are saying, Mr. Townsend, is that a person who cannot afford a drug that has been prescribed for him by a doctor to purchase, provisions are made for him by the community in one form or another to pay for it for him?

MR. TOWNSEND: Not in all cases. I

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COMMISSIONER FRASTONE: [illegible] continue with the questioning, Mr. Townsend. I am just wondering what happens in a case where a doctor says to a patient: "My dear man, you are ill and you need some particular drug". Can that person afford now to buy the drug?

MR. TOWNSEND: No, [illegible]

Now, he may not have the money to buy the drug. What will happen in a case like that?

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MR. TOWNSEND: Not in all cases. [illegible]

feel that there are some cases that do not get these drugs

COMMISSIONER FIRESTONE: But would you be in favour of those people who at the moment are not getting those drugs when they are prescribed by the doctor as being essential to his health and welfare, that they should get those drugs?

MR. TOWNSEND: Absolutely, sir.

COMMISSIONER FIRESTONE: So you are saying that those who cannot afford to pay should be provided with those drugs through a community scheme or effort?

MR. TOWNSEND: Yes, sir.

COMMISSIONER FIRESTONE: And are you also saying that those who can afford to pay for drugs should pay for them?

MR. TOWNSEND: I wouldn't like to be tied down on this, Dr. Firestone. I think that if we have to study the population as a whole, and if you are going to class an indigent and a person that can pay, and if we find from further studies that it is necessary, that people are not getting the proper medication, then I would be in favour of submitting that it would be national and the people would be paying into a national scheme, rather than one that somebody can pay and the government just pick up the tab for those who cannot pay.

COMMISSIONER FIRESTONE: Let me help you. People go and see their doctor, and the doctor says: "My dear man, you are sick, you need that drug". And the man has enough money in his pocket to buy the drug, and goes to the drugstore and buys it. Would you say that

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[illegible]

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"My dear man, you are sick, you need that drug". And

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is a proper system?

MR. TOWNSEND: Yes.

COMMISSIONER FIRESTONE: And another person has not the money, and goes to a community organization and gets the drug this way, is this the system at the moment?

MR. TOWNSEND: Yes.

COMMISSIONER FIRESTONE: Are you in favour of the system that the people who can pay for the drugs and the people who cannot pay for it get it supplied in some other way?

MR. TOWNSEND: Yes.

COMMISSIONER FIRESTONE: If you multiply that by all the people in the Province of New Brunswick, and by all the prescriptions the doctors prescribe, you will get the total drug bill for the Province of New Brunswick, isn't that right?

MR. TOWNSEND: That is correct.

COMMISSIONER FIRESTONE: Can the Province of New Brunswick afford a scheme that does not provide for the payment of drugs which doctors prescribe as being essential for the health of their patients?

MR.TOWNSEND: I think, sir, that I would like to think that one over very carefully.

COMMISSIONER FIRESTONE: Well, I have no objection to you thinking about it very carefully, and if you wish to provide us the answer in a written statement, you are more than welcome to do so.

MR. TOWNSEND: I would, sir.

COMMISSIONER FIRESTONE: But, as I

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COMMISSIONER FIRESTONE: Well, I have no objection to you thinking about it very carefully, and if you wish to provide us the answer in a written statement, [illegible]

[illegible]

COMMISSIONER FIRESTONE: But, as I

understand what you have been telling us so far, you are in favour that people who can afford to pay for it pay for it, people who can't afford to do not pay for it, but get it through some community effort, and therefore, the Province of New Brunswick must find some ways and means to pay the drug bill. If my understanding is not correct, please correct me.

MR. TOWNSEND: Yes, we are thinking of a total, but then were you thinking just of the people who couldn't afford to pay?

COMMISSIONER FIRESTONE: If you permit me, sir, I have been addressing this question to you, and if I may restate the question. Can we afford not to pay for the drugs, can you afford not to pay for the drugs which the people in the Province of New Brunswick require?

MR. TOWNSEND: Definitely not, sir.

COMMISSIONER FIRESTONE: Fine. So I think you have given us the answer whether you can afford it or not. I think the answer you have given us is yes. If I may turn to the next question, you have been speaking about over-utilization?

MR. TOWNSEND: Yes, sir.

COMMISSIONER FIRESTONE: And you expressed some views about over-utilization. Tell me, Mr. Townsend, do you think the pharmacists are in a good position to judge whether drugs are over-utilized or not, or wouldn't you feel the physicians are in a somewhat better position to judge whether drugs are over-utilized or not?

MR. TOWNSEND: I cannot see any

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COMMISSIONER FINKELTOWER: If you permit me, sir, I have been addressing this question to you, and if I may restate the question, can we afford not to pay for the drugs, can you afford not to pay for the drugs which the people in the Province of New Brunswick [illegible]

MR. TOWNSEND: Definitely [illegible]

COMMISSIONER FINKELTOWER: Fine. So I think you have given us the answer whether you can afford it or not. I think the answer you have given us is yes. If I may turn to the next question, you have been speaking about over-utilization?

COMMISSIONER FINKELTOWER: And you expressed some views about over-utilization. Tell me, Mr. Townsend, do you think the pharmacists are in a good position to judge whether drugs are over-utilized or not, or wouldn't you feel the physicians are in a somewhat better position to judge whether drugs are over-utilized or not?

physician judging that, sir.

COMMISSIONER FIRESTONE: Are you suggesting that over-utilization arises out of physicians prescribing more drugs than their patients require?

MR. TOWNSEND: No, sir.

COMMISSIONER FIRESTONE: All right, would you then care to elaborate for the benefit of the Commission as to what you mean when you speak of over-utilization?

MR. TOWNSEND: I think, Dr. Firestone I made a reference to that before, and that over-utilization is a term -- increased utilization I think would be a better term. I was careful to say that we weren't sure at the present time whether or not our utilization rate was correct, whether or not we had reached the point where people were getting the drug supplies they needed. I frankly don't know this.

COMMISSIONER FIRESTONE: Well then, your first statement therefore is taken that we should correct the word over-utilization, and should substitute the word increased utilization?

MR. TOWNSEND: Yes, sir.

COMMISSIONER FIRESTONE: And would you feel, sir, that physicians would be the best judges whether utilization of drugs should be increased or not? After all, they prescribe the drugs the patient requires. Should not we leave the judgment to the physician?

MR. TOWNSEND: Oh, yes. I misinterpreted your question before. Yes.

COMMISSIONER FIRESTONE: And therefore

physician judging that, sir.

COMMISSIONER FIRESTONE: Are you [illegible]

MR. TOWNSEND: No, sir.

COMMISSIONER FIRESTONE: [illegible] would you then care to elaborate for the benefit of the [illegible]

MR. TOWNSEND: I think, Commissioner, I made a reference to that before, and that over-utilization is a term -- increased utilization I think would be a better term. I was careful to say that we were not sure at the present time whether or not our utilization rate was correct, whether or not we had reached the point where people were getting the drug unnecessarily [illegible]

Your first statement therefore is taken that we should correct the word over-utilization, and should substitute the word increased utilization?

MR. TOWNSEND: Yes, sir.

You feel, sir, that physicians would be the best judge whether utilization of drugs should be increased or not? After all, they prescribe the drugs the patient receives. Should not we leave the judgment to the physician?

[illegible] posed your question before. Yes.

COMMISSIONER F[illegible]

we have come to the conclusion that while pharmacists are great people when it comes to dispensing drugs, they are not necessarily the best judges of either over-utilization or increased utilization of drugs, with no reflection on the professional competence of the witnesses.

MR. TOWNSEND: That is right.

COMMISSIONER FIRESTONE: The question of competition. You spoke of competition among retailers. Can you explain to us what form that competition takes when it comes to the sale of drugs at the retail level?

MR. TOWNSEND: I would say possibly the same as physicians, lawyers. We advertise, we put up prescriptions, we service, we run deliveries, we try to just go probably one step further than the next man in giving a service to the public.

COMMISSIONER FIRESTONE: Is there price competition on some of the major drug items?

MR. TOWNSEND: Yes, sir. There is.

COMMISSIONER FIRESTONE: If we were to ask your association, would it be possible for you to provide us with specific information as to the various prices charged in major drugs by leading retailers in the province, without necessarily divulging their names. We are not necessarily interested in any particular firm, but we would have perhaps some idea of the degree of price competition that exists. Would that be possible?

MR. TOWNSEND: Yes, sir.

COMMISSIONER FIRESTONE: Are you also familiar with the prices which hospitals pay for drugs?

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COMMISSIONER FINKELSTEIN: Are you

also familiar with the prices which hospitals pay for

drugs?

MR. TOWNSEND: Yes, I certainly am, sir.

COMMISSIONER FIRESTONE: Would it be possible for you to supply us also that information, so that the Commission would have an indication of the differentials?

MR. TOWNSEND: Yes, sir. Dr. Kelly has been very helpful to us in all our brief, and I am sure he would be helpful.

THE CHAIRMAN: For my information, do you mean the price for which they both obtain their drugs, the source from which they both obtain their drugs?

COMMISSIONER FIRESTONE: Perhaps I can elaborate then, Mr. Chairman. Thank you for raising the question. I am asking for the prices at which hospitals obtain the drugs, and I understand that the drugs are made available either free of charge or at cost. How are these drugs purchased by hospitals made available to out patients?

MR. TOWNSEND: They are not made available in this province to out-patients.

COMMISSIONER FIRESTONE: So therefore, what we would have is the cost of drugs to the hospital?

MR. TOWNSEND: That is correct.

COMMISSIONER FIRESTONE: We would also have, or your association presumably would have, the cost of drugs to the retailer?

MR. TOWNSEND: Yes.

COMMISSIONER FIRESTONE: And you would

MR. TOWNSEND: Yes, I certainly am, sir.

COMMISSIONER FIRESTONE: Would it be possible for you to supply us also that information, so that the Commission would have an indication of the differentials?

MR. TOWNSEND: Yes, sir. Mr. Kohl has been very helpful to us in all our brief, and I am sure he would be helpful.

THE CHAIRMAN: For my information, do you mean the price for which they been sold, that drugs, the source from which they been obtained, their drugs?

COMMISSIONER FIRESTONE: Either, I elaborate then, Mr. Chairman. Thank you for clarifying the question. I am asking for the price at which they obtain the drugs, and I understand such drugs are made available either free of charge or at cost. Is these drugs purchased by hospitals made available in particular?

MR. TOWNSEND: They are not made available in this province to out-patients.

What we would have is the cost of drugs to the hospital.

MR. TOWNSEND: That is correct.

Also have, or your association presumably would have, the cost of drugs to the patient?

MR. TOWNSEND: Yes.

COMMISSIONER FIRESTONE: And you would

also have the cost of drugs to the patient, to the purchaser by purchasing drugs in a retail outlet, so there would be three figures involved for each item. These three figures are available?

MR. TOWNSEND: We can work to make them available, sir.

COMMISSIONER FIRESTONE: We are not asking for a comprehensive survey. We are more interested in an illustration of the differentials which exist, so therefore if you would pick a few key drugs, just to illustrate to us, it would be very helpful. Is that possible?

MR. TOWNSEND: Yes, sir. It is possible, but we must remember that in some cases the hospital pharmacists work with a greater professional freedom than retail pharmacists. I [illegible] but I think that the hospitals have the right to substitute a number of proprietory drugs for a trade name. This we have not the right to do. We might have a hospital buying one brand of drugs and a retailer buying another brand.

COMMISSIONER FIRESTONE: Well, I think this is a very useful qualification you are making, Mr. Townsend, and we would welcome in addition to the factual information any qualification which you may wish to add, and thank you very much.

COMMISSIONER BALTZAN: There is one area where you can assist in the matter of this question of utilization, and I refer to drugs not on the restricted list, where patients come in for a repeat prescription

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possible, but we must remember that in some cases you

hospital pharmacists work with a greater [illegible]

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of utilization, and I refer to drugs not on the hospital

list, where patients come in for a repeat prescription

without instructions by physicians to continue on this for, say, a week or a month, and then maybe they continue on for a year, and you are then in a little bit better position to assist with respect to this problem than a physician who does not know anything about it.

MR. TOWNSEND: That is correct, sir, but those cases I think are isolated as far as the letter of the law laying down the filling of prescriptions is concerned, especially since last September 21st.

COMMISSIONER McCUTCHEON: I put it to you another way, Mr. Townsend: there is a great list of drugs -- and I think you have a hundred of them listed here -- which can under certain circumstances be sold without any prescription?

MR. TOWNSEND: That is correct.

COMMISSIONER McCUTCHEON: So in that situation the responsibility is entirely yours?

MR. TOWNSEND: That is correct.

COMMISSIONER McCUTCHEON: When you say that you are in favour of a scheme under which people who can pay for their drugs do so, and people who cannot pay for them the community pays for them, do you include that type of drug in your statement?

MR. TOWNSEND: No, sir. What we intended in there were prescription drugs, what is known as anything the physician writes down as a prescription; not, as we call it, over-the-counter medication. This we don't feel should come under the health organizations, because it would just become too involved. We have also, of course -- to amplify it still further -- the fact that many of these drugs are sold in grocery stores, and we just would not have any idea of where to obtain figures except from the manufacturers.

COMMISSIONER McCUTCHEON: So, any figures you give us as to drug sales will be limited to prescription drugs?

MR. TOWNSEND: That is correct.

COMMISSIONER McCUTCHEON: Would you like to hazard any guess from your own experience as to

Townsend

COMMISSIONER MOUTCHENKO: I put it in another way, Mr. Townsend: there is a great list of drugs -- and I think you have a hundred of them listed here -- which can under certain circumstances be sold without any prescription?

MR. TOWNSEND: That is correct.

COMMISSIONER MOUTCHENKO: So in that situation the responsibility is entirely yours?

MR. TOWNSEND: That is correct.

COMMISSIONER MOUTCHENKO: When you [illegible] who can pay for their drugs do so, and people who cannot pay for them the community pays for them, do you include that type of drug in your statement?

[illegible] included in these prescription drugs, and it is more as anything the pay-as-you-go wages down as a prescription, not, as we call it, over-the-counter medicine. While we don't feel should come under the health insurance, because it would just become too involved. We have [illegible] of course -- to amplify it still further -- the fact that many of these drugs are sold in grocery stores, and we just would not have any idea of where to obtain them, except from the manufacturers.

COMMISSIONER MOUTCHENKO: So, but figures you give us as to drug sales will be limited to prescription drugs?

MR. TOWNSEND: That is correct.

[illegible] to hazard any guess

the proportion of prescription drugs you sell in dollar volume and the proportion of non-prescription drugs?

MR. TOWNSEND: That question was as to what we would refer to as over-the-counter drugs versus prescription drugs?

COMMISSIONER McCUTCHEON: That is right.

MR. TOWNSEND: I would not want to hazard that at all.

COMMISSIONER McCUTCHEON: Could you get us that information from two or three representative pharmacists in your association?

MR. TOWNSEND: We can try, but I might point out that most of our association run retail pharmacies of possibly less than $1,000.00 a year, and to carry detailed information is very difficult.

COMMISSIONER McCUTCHEON: But there may be someone who has kept that information?

MR. TOWNSEND: Yes.

COMMISSIONER McCUTCHEON: I agree if it has not been kept you cannot get it.

THE CHAIRMAN: Thank you very much, gentlemen.

MR. TOWNSEND: Thank you very much, Mr. Chairman.

THE CHAIRMAN: Now, this concludes the list of those whose submissions we were to hear today. We will proceed at 9 o'clock tomorrow morning starting with the submission of the New Brunswick Medical Society in co-operation with the Medical Council of New Brunswick, to be followed by the New Brunswick Association of

the p[illegible]

[illegible]

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MR. TOWNSEND: Yes.

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THE CHAIRMAN: Thank you very much,

gentlemen.

MR. TOWNSEND: Thank you very much.

[illegible]

THE CHAIRMAN: Now, this concludes

the list of those whose submissions we were to hear today.

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[illegible]

to be followed by the New Brunswick Association of

Registered Nurses, the Canadian Mental Health Associati
and the New Brunswick Association for Retarded Children,
those being the four remaining submissions of which we
have had notice.

The hearing stands adjourned until
9 o'clock tomorrow morning.

--- Adjournment.